Agenda Item No: **3E-5**

PALM BEACH COUNTY
BOARD OF COUNTY COMMISSIONERS

AGENDA ITEM SUMMARY

Meeting Date: June 19, 2007	**[X] Consent**	**[ ] Regular**
	[ ] Workshop	**[ ] Public Hearing**

Department

Submitted By: Community Services

Submitted For: Ryan White

I. EXECUTIVE BRIEF

Motion and Title: Staff recommends motion to ratify: the Chairperson's signature on the Minority AIDS Initiative (MAI) grant application for the period August 1, 2007, through July 31, 2008 in the amount of $1,150,000 with the Department of Health and Human Services Health Resources and Services Administration (HRSA).

Summary: The 2007 MAI funds will provide enhanced and increased services to core medical and other support HIV related services to targeted areas throughout Palm Beach County. No County funds are required. (Ryan White) Countywide (TKF)

Background and Justification: On April 30, 2007, the Department of Health and Human Services Health Resources and Services Administration (HRSA) issued the FY 2007 Minority AIDS Initiative grant application and requested that the signed application be submitted no later than May 29, 2007. In accordance with PPM No. CW-F-003, the Chairperson's signature was obtained prior to Board review and action in order to comply with the HRSA submission deadline.

Attachments: 2007 MAI application

Recommended by: [signature] 5-31-2007
Department Director — Date

Approved by: [signature] 6/7/07
Assistant County Administrator — Date

II. FISCAL IMPACT ANALYSIS

A. Five Year Summary of Fiscal Impact:

Fiscal Years	2007	2008	2009	2010	2011
Capital Expenditures					
Operating Costs					
External Revenues					
Program Income (County)					
In-Kind Match (County)					
NET FISCAL IMPACT	0				
# ADDITIONAL FTE POSITIONS (Cumulative)					

Is Item Included in Current Budget? Yes____ No ✓
Budget Account No.: Fund: ____ Dept:____ Unit______ Object: ____
Program Code ____

B. Recommended Sources of Funds/Summary of Fiscal Impact:

Department of Health and Human Services Health Resources and Services Administration (HRSA)

C. Departmental Fiscal Review: [signature]

III. REVIEW COMMENTS

A. OFMB Fiscal and/or Contract Administration Comments:
Budget will be amended once the grant is awarded.

[signature] 6-6-07
OFMB
6/4/07 6/5/07 06/04/07 6/4/7

[signature] 6/7/07
Contract Dev. and Control

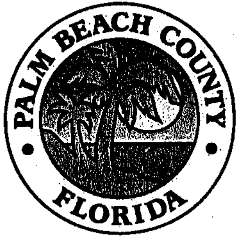
B. Legal Sufficiency:

[signature] 6/7/07
Assistant County Attorney

C. Other Department Review:

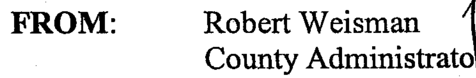
____
Department Director

This summary is not to be used as a basis for payment.



MEMORANDUM

TO: Addie L. Greene, Chairperson and the Board of County Commissioners

FROM: Robert Weisman, County Administrator 

DATE: May 23, 2007

RE: **RYAN WHITE PART A MINORITY AIDS INITIATIVE GRANT APPLICATION**

Department of Community Services
810 Datura Street
West Palm Beach, FL 33401
(561) 355-4700
FAX: (561) 355-3863
www.pbcgov.com

Palm Beach County Board of County Commissioners

Addie L. Greene, Chairperson

Jeff Koons, Vice Chair

Karen T. Marcus

Warren H. Newell

Mary McCarty

Burt Aaronson

Jess R. Santamaria

County Administrator

Robert Weisman

Pursuant to PPM#CW-F-003 your signature is needed on the Minority AIDS Initiative Grant Application. This application for $1,150,000 will provide assistance to Minority AIDS affected individuals and families in Palm Beach County.

The application was received on April 30, 2007 with instructions to return it by May 29, 2007. The emergency signature process is being utilized because there is not sufficient time to submit the application through the regular BOCC agenda process. Staff will submit this item at the Board's June 19, 2007 Commission Agenda.

If additional information is needed, please contact Gayle Corso, Program Coordinator at (561) 355-4730.

Assistant County Attorney

OFMB

"An Equal Opportunity Affirmative Action Employer"

printed on recycled paper

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424

Version 02

* 1. Type of Submission:	* 2. Type of Application:	* If Revision, select appropriate letter(s):
☐ Preapplication	☑ New	
☑ Application	☐ Continuation	* Other (Specify)
☐ Changed/Corrected Application	☐ Revision	

* 3. Date Received: Completed by Grants.gov upon submission.
4. Applicant Identifier:

5a. Federal Entity Identifier:
* 5b. Federal Award Identifier:

State Use Only:

6. Date Received by State:
7. State Application Identifier:

8. APPLICANT INFORMATION:

* a. Legal Name: Palm Beach County FL Board ofCounty Commissioners

* b. Employer/Taxpayer Identification Number (EIN/TIN): 59-6000785
* c. Organizational DUNS: 108663810

d. Address:

* Street1: 810 Datura Street
Street2:
* City: West Palm Beach
County: Palm Beach
* State: FL: Florida
Province:
* Country: USA: UNITED STATES
* Zip / Postal Code: 33401

e. Organizational Unit:

Department Name: Department Community Services
Division Name: Administration

f. Name and contact information of person to be contacted on matters involving this application:

Prefix: Mr.
* First Name: Edward
Middle Name:
* Last Name: Rich
Suffix:

Title: Director

Organizational Affiliation:
Palm Beach County Department of Community Services

* Telephone Number: 561-355-4702
Fax Number: 561-355-3863

* Email: erich@co.palm-beach.fl.us

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424

Version 02

9. Type of Applicant 1: Select Applicant Type:

B: County Government

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

*** 10. Name of Federal Agency:**

Health Resources & Services Administration

11. Catalog of Federal Domestic Assistance Number:

93.914

CFDA Title:

HIV Emergency Relief Project Grants

*** 12. Funding Opportunity Number:**

HRSA-07-135

* Title:

Minority AIDS Initiative Programs for Part A Grantees

13. Competition Identification Number:

2833

Title:

14. Areas Affected by Project (Cities, Counties, States, etc.):

County-Wide

*** 15. Descriptive Title of Applicant's Project:**

Minority AIDS Initiative- medical case management, drug reimbursement(local), oral health (dental), food bank/homedelivered meals and medical transportation for Afro-Americans, Haitians & Hispanics.

Attach supporting documents as specified in agency instructions.

Add Attachments | Delete Attachments | View Attachments

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424

Version 02

16. Congressional Districts Of:

* a. Applicant: attach
* b. Program/Project: attach

Attach an additional list of Program/Project Congressional Districts if needed.

Add Attachment | Delete Attachment | View Attachment

17. Proposed Project:

* a. Start Date: 08/01/2007
* b. End Date: 07/31/2008

18. Estimated Funding ($):

* a. Federal	1,150,000.00
* b. Applicant	0.00
* c. State	0.00
* d. Local	0.00
* e. Other	0.00
* f. Program Income	0.00
* g. TOTAL	1,150,000.00

*** 19. Is Application Subject to Review By State Under Executive Order 12372 Process?**

☐ a. This application was made available to the State under the Executive Order 12372 Process for review on ______ .

☐ b. Program is subject to E.O. 12372 but has not been selected by the State for review.

☑ c. Program is not covered by E.O. 12372.

*** 20. Is the Applicant Delinquent On Any Federal Debt? (If "Yes", provide explanation.)**

☐ Yes ☑ No Explanation

21. *By signing this application, I certify (1) to the statements contained in the list of certifications and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances** and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 218, Section 1001)**

☑ **** I AGREE**

** The list of certifications and assurances, or an internet site where you may obtain this list, is contained in the announcement or agency specific instructions.

Authorized Representative:

Prefix:
* First Name: Addie
Middle Name: L.
* Last Name: Greene
Suffix:

* Title: Chair person/County Commissioner

Addie L. Greene

* Telephone Number: 561-355-2207
Fax Number:

* Email: agreene@co.palm-beach.fl.us

* Signature of Authorized Representative: Completed by Grants.gov upon submission.
* Date Signed: Completed by Grants.gov upon submission.

APPROVED AS TO FORM AND LEGAL SUFFICIENCY

COUNTY ATTORNEY

OMB Approval No. 0348-0044

BUDGET INFORMATION - Non-Construction Programs

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. MAI Grant Program	93.914	$	$	$ 1,150,000.00	$	$ 1,150,000.00
2.						0.00
3.						0.00
4.						0.00
5. TOTALS		$ 0.00	$ 0.00	$ 1,150,000.00	$ 0.00	$ 1,150,000.00

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY				Total (5)
	(1)	(2)	(3)	(4)	
a. Personnel	$	$	$	$	$ 0.00
b. Fringe Benefits					0.00
c. Travel					0.00
d. Equipment					0.00
e. Supplies					0.00
f. Contractual	100,000.00	50,000.00	1,000,000.00		1,150,000.00
g. Construction					0.00
h. Other					0.00
i. Total Direct Charges *(sum of 6a - 6h)*	100,000.00	50,000.00	1,000,000.00	0.00	1,150,000.00
j. Indirect Charges					0.00
k. TOTALS *(sum of 6i and 6j)*	$ 100,000.00	$ 50,000.00	$ 1,000,000.00	$ 0.00	$ 1,150,000.00
7. Program Income	$	$	$	$	$ 0.00

SECTION C - NON-FEDERAL RESOURCES

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e) TOTALS
8.	$	$	$	$ 0.00
9.				0.00
10.				0.00
11.				0.00
12. TOTALS *(sum of lines 8 and 11)*	$ 0.00	$ 0.00	$ 0.00	$ 0.00

SECTION D - FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	$ 0.00	$	$	$	$
14. Non-Federal	0.00				
15. TOTAL *(sum of lines 13 and 14)*	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT

(a) Grant Program	FUTURE FUNDING PERIODS (Years)			
	(b) First	(c) Second	(d) Third	(e) Fourth
16. MAI Grant Program	$ 1,150,000.00	$ 1,150,000.00	$ 1,150,000.00	$
17.				
18.				
19.	$	$	$	$
20. TOTALS *(sum of lines 16 - 19)*	$1,150,000.00	$1,150,000.00	$1,150,000.00	$0.00

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges:	22. Indirect Charges:
23. Remarks	

OMB Approval No. 0348-0040

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply with all applicable requirements of all other Federal laws, executive orders, re- gulations and policies governing this program.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE Addie L. Greene Addie L. Greene, Chairperson
APPLICANT ORGANIZATION Palm Beach County Board of County Commissioners	DATE SUBMITTED 5/23/07

APPROVED AS TO FORM
AND LEGAL SUFFICIENCY
COUNTY ATTORNEY

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

(a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;

(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and

(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, In eligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub- grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing an ongoing drug-free awareness program to inform employees about--
  (1) The dangers of drug abuse in the workplace;
  (2) The grantee's policy of maintaining a drug-free workplace;
  (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
  (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

(d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
  (1) Abide by the terms of the statement; and
  (2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

(e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central

point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted--
    (1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget
Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical an mental health of the American people.

APPROVED AS TO FORM
AND LEGAL SUFFICIENCY

COUNTY ATTORNEY

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE Addie L. Greene, Chairperson	
APPLICANT ORGANIZATION Palm Beach County Board of County Commissioners		DATE SUBMITTED 5/23/07

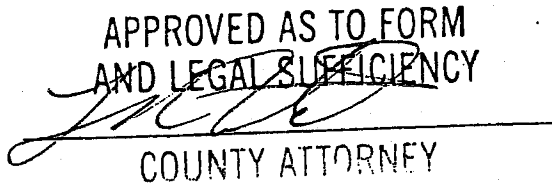
DISCLOSURE OF LOBBYING ACTIVITIES

Approved by OMB 0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure.)

1. Type of Federal Action:	**2. Status of Federal Action**	**3. Report Type:**
☐ a. contract b. grant c. cooperative agreement d. loan e. loan guarantee f. loan insurance	☐ a. bid/offer/application b. initial award c. post-award	☐ a. initial filing b. material change **For Material Change Only:** Year ______ Quarter ______ date of last report ______

4. Name and Address of Reporting Entity: ☐ Prime ☐ Subawardee Tier ______, *if known:* NOT APPLICABLE **Congressional District,** *if known:*	**5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:** **Congressional District,** *if known:*
6. Federal Department/Agency:	**7. Federal Program Name/Description:** **CFDA Number,** *if applicable:* ______
8. Federal Action Number, *if known:*	**9. Award Amount,** *if known:* $
10. a. Name and Address of Lobbying Entity *(if individual, last name, first name, MI):*	**b. Individuals Performing Services** *(including address if different from No. 10a.) (last name, first name, MI):*
11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.	Signature: Addie L. Greene Print Name: Addie L. Greene Title: Chair Person Telephone No.: (561) 355-2207 Date: 5/23/07
Federal Use Only:	Authorized for Local Reproduction Standard Form - LLL (Rev. 7-97)



APPROVED AS TO FORM
AND LEGAL SUFFICIENCY

COUNTY ATTORNEY

OMB Approval No. 0920-0428
Expiration Date: April 30, 2000

CHECKLIST

Public Burden Statement: Public reporting burden of this collection of information is estimated to average 4 - 50 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, Clearance Officer, 1600 Clifton Road, MS D-24, Atlanta, GA 30333, ATTN: PRA (0920-0428). Do not send the completed form to this address.

NOTE TO APPLICANT: This form must be completed and submitted with the original of your application. Be sure to complete both sides of this form. Check the appropriate boxes and provide the information requested. This form should be attached as the last page of the signed original of the application. This page is reserved for PHS staff use only.

Type of Application: ☑ NEW ☐ Noncompeting Continuation ☐ Competing Continuation ☐ Supplemental

PART A: The following checklist is provided to assure that proper signatures, assurances, and certifications have been submitted.

	Included	NOT Applicable
1. Proper Signature and Date for Item 18 on SF 424 (FACE PAGE)	☑	
2. Proper Signature and Date on PHS-5161-1 "Certifications" page.	☑	
3. Proper Signature and Date on appropriate "Assurances" page, i.e., SF-424B (Non-Construction Programs) or SF-424D (Construction Programs)	☑	
4. If your organization currently has on file with DHHS the following assurances, please identify which have been filed by indicating the date of such filing on the line provided. (All four have been consolidated into a single form, HHS Form 690)		

- ☐ Civil Rights Assurance (45 CFR 80) ____________
- ☐ Assurance Concerning the Handicapped (45 CFR 84) ____________
- ☐ Assurance Concerning Sex Discrimination (45 CFR 86) ____________
- ☐ Assurance Concerning Age Discrimination (45 CFR 90 & 45 CFR 91) ____________

	Included	NOT Applicable
5. Human Subjects Certification, when applicable (45 CFR 46)	☐	☐

PART B: This part is provided to assure that pertinent information has been addressed and included in the application.

	YES	NOT Applicable
1. Has a Public Health System Impact Statement for the proposed program/project been completed and distributed as required?	☐	☑
2. Has the appropriate box been checked for item # 16 on the SF-424 (FACE PAGE) regarding intergovernmental review under E.O. 12372 ? (45 CFR Part 100)	☑	
3. Has the entire proposed project period been identified in item # 13 of the FACE PAGE?	☑	
4. Have biographical sketch(es) with job description(s) been attached, when required?	☑	☐
5. Has the "Budget Information" page, SF-424A (Non-Construction Programs) or SF-424C (Construction Programs), been completed and included?	☑	
6. Has the 12 month detailed budget been provided?	☑	☐
7. Has the budget for the entire proposed project period with sufficient detail been provided?	☑	☐
8. For a Supplemental application, does the detailed budget address only the additional funds requested?	☐	☑
9. For Competing Continuation and Supplemental applications, has a progress report been included?	☐	☑

PART C: In the spaces provided below, please provide the requested information.

Business Official to be notified if an award is to be made.	Program Director/Project Director/Principal Investigator designated to direct the proposed project or program.
Name Addie L. Greene	Name Edward L. Rich
Title Chair Person	Title Director
Organization PBCBCC	Organization Community Services Department
Address 301 N. Olive Avenue, West Palm Beach, FL	Address 810 Datira Street, West Palm Beach, FL.
E-mail Address agreene@co.palm-beach.fl.us	E-mail Address erich@co.palm-beach.fl.us
Telephone Number (561) 355-2207	Telephone Number (561) 355-4702
Fax Number (561) 355-3990	Fax Number (561) 355-3863

APPLICANT ORGANIZATION'S 12-DIGIT DHHS EIN (If already assigned)	SOCIAL SECURITY NUMBER	HIGHEST DEGREE EARNED
1596000785A1	___ - __ - ____	

(OVER)

PART D: A private, nonprofit organization must include evidence of its nonprofit status with the application. Any of the following is acceptable evidence. Check the appropriate box or complete the "Previously Filed" section, whichever is applicable.

- ☐ (a) A reference to the organization's listing in the Internal Revenue Service's (IRS) most recent list of tax-exempt organizations described in section 501(c)(3) of the IRS Code.
- ☐ (b) A copy of a currently valid Internal Revenue Service Tax exemption certificate.
- ☐ (c) A statement from a State taxing body, State Attorney General, or other appropriate State official certifying that the applicant organization has a nonprofit status and that none of the net earnings accrue to any private shareholders or individuals.
- ☐ (d) A certified copy of the organization's certificate of incorporation or similar document if it clearly establishes the nonprofit status of the organization.
- ☐ (e) Any of the above proof for a State or national parent organization, and a statement signed by the parent organization that the applicant organization is a local nonprofit affiliate.

If an applicant has evidence of current nonprofit status on file with an agency of PHS, it will not be necessary to file similar papers again, but the place and date of filing must be indicated.

Previously Filed with: *(Agency)* ______________________ *on (Date)* __________

INVENTIONS

If this is an application for continued support, include: (1) the report of inventions conceived or reduced to practice required by the terms and conditions of the grant; or (2) a list of inventions already reported, or (3) a negative certification.

EXECUTIVE ORDER 12372

Effective September 30, 1983, Executive Order 12372 (Intergovernmental Review of Federal Programs) directed OMB to abolish OMB Circular A-95 and establish a new process for consulting with State and local elected officials on proposed Federal financial assistance. The Department of Health and Human Services implemented the Executive Order through regulations at 45 CFR Part 100 (Inter-governmental Review of Department of Health and Human Services Programs and Activities). The objectives of the Executive Order are to (1) increase State flexibility to design a consultation process and select the programs it wishes to review, (2) increase the ability of State and local elected officials to influence Federal decisions and (3) compel Federal officials to be responsive to State concerns, or explain the reasons.

The regulations at 45 CFR Part 100 were published in the *Federal Register* on June 24, 1983, along with a notice identifying the Department's programs that are subject to the provisions of Executive Order 12372. Information regarding PHS programs subject to Executive Order 12372 is also available from the appropriate awarding office.

States participating in this program establish State Single Points of Contact (SPOCs) to coordinate and manage the review and comment on proposed Federal financial assistance. Applicants should contact the Governor's office for information regarding the SPOC, programs selected for review, and the consultation (review) process designed by their State.

Applicants are to certify on the face page of the SF-424 (attached) whether the request is for a program covered under Executive Order 12372 and, where appropriate, whether the State has been given an opportunity to comment.

Appendix C: Agreements and Compliance Assurances for the FY 2007 Part A Minority AIDS Initiative Grant

The Chief Elected Official (CEO) of all Part A-Emergency Relief for Areas with Substantial Need for Services (Part A), or her/his designee, must include a signed copy of the attached assurances with the Part F, Subpart III-Minority AIDS Initiative (MAI) application, that must be satisfied in order to qualify for a MAI grant award as required under Title XXVI of the Public Health Service Act as amended by the RYAN WHITE HIV/AIDS TREATMENT MODERNIZATION ACT OF 2006.

RYAN WHITE HIV/AIDS TREATMENT MODERNIZATION ACT OF 2006
FY 2007 Part A MAI Agreements and Compliance Assurances

I, the Chief Elected Official for the *Part A-Emergency Relief for Areas with Substantial Need for Services* (hereinafter referred to as *Part A*) grant in West Palm Beach, Palm Beach County as designated pursuant to Title XXVI of the Public Health Service (PHS) Act as amended by the Ryan White HIV/AIDS Treatment Modernization Act of 2006, do hereby certify that:

A. Pursuant to Section 2693(b)(2)(A) of the PHS Act, MAI funds will be used for the purpose of improving *"...HIV-related health outcomes to reduce existing racial and ethic health disparities;* and

B. MAI funds and services will be allocated and administered in accordance with the *FY 2007 Part A Ryan White Program Agreements and Compliance Assurances* submitted to the Health Resources and Services Administration.

SIGNED: Addie L. Greene **(Chief Elected Official)**

Title: Chairperson, Palm Beach County Board of County Commissioners

Date signed: 5/23/07

APPROVED AS TO FORM AND LEGAL SUFFICIENCY

COUNTY ATTORNEY

PROGRAM NARRATIVE

1. DEMONSTRATED NEED

This section describes the severity of the HIV/AIDS epidemic in the West Palm Beach EMA using quantitative epidemiological data; co-morbidities, costs and complexities of providing care; the service needs of special populations; and unique service delivery challenges. The purpose of this section is to explain why supplemental funding for services is needed for people living with HIV disease in Palm Beach County.

Palm Beach County Demographics

Palm Beach County is a geographically large (2,200 square miles) and demographically diverse EMA. The county is the largest of the state's 67 counties and is located on the southeast coast of the peninsula. Most of the population is concentrated in the coastal area between the Atlantic Ocean and the Florida Turnpike. The western portion of the county is predominantly rural. The county is remarkable for its extraordinary socioeconomic contrasts, ranging from one of the nation's wealthiest municipalities, Palm Beach, on the Atlantic Ocean, to one of its poorest, Belle Glade, on the shores of Lake Okeechobee in the extreme western portion of the county.

The 2005 mid-year population estimate for Palm Beach County was 1,277,645. Of these, 49% were male and 51% female. The county is racially and ethnically diverse. In 2005, 68% of the population was White non-Hispanic, 15% was Black non-Hispanic, 14% was Hispanic, and 2% was other races/ethnicities. A large proportion of the county's population is composed of senior retirees. The 2005 age distribution in years was as follows: 0-12, 15%; 13-19, 8%; 20-24, 6%; 25-29, 5%; 30-39, 12%; 40-49, 15%; 50-59, 13%; 60+, 27%.[1] Additionally, an estimated 20% of the county's residents were foreign-born.[2] There are more than 65,000 foreign-born seasonal farm workers estimated to be in the county.[3] Many of these are from the Caribbean, Central America, and Mexico. In recent years, many immigrant workers have become employed in construction, landscaping, and other jobs throughout the county, especially the suburban coastal areas.[4]

a) HIV/AIDS Epidemiology

This sub-section describes Palm Beach County's AIDS Incidence, AIDS prevalence, and HIV (not AIDS) prevalence by demographic characteristics and exposure category; trends in incidence and prevalence over time; the disproportionate impact of HIV/AIDS on certain populations; populations of PLWHA that are underrepresented in the CARE Act-funded system of HIV/AIDS primary medical care; and the estimated level of service gaps among PLWHA **(Attachment 3).**

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[1] Florida Department of Health, Bureau of HIV/AIDS Surveillance Section (2006). *Epidemiological Profile, Palm Beach County.*
[2] U.S. Census Bureau (2006). *2005 American Community Survey Data Profile Highlights, Palm Beach County.*
[3] Treasure Coast Health Council (2006). *Palm Beach County EMA Comprehensive Plan.*
[4] Ibid.

Incidence and Prevalence

In 2005, a total of 6,833 people were reported to be living with HIV/AIDS (PLWHA) in Palm Beach County.[5] Using the total population estimate from the previous page yields an overall PLWHA prevalence rate per of 535 per 100,000 population in Palm Beach County (6,833/1,277,645 X 100,000). In other words, 1 in 187 people in Palm Beach County is reported to be living with HIV/AIDS. In comparison, the analogous rate for the State of Florida is 417, or 1 in 240 people.[6]

More blacks in Florida are living with HIV or are already dead from AIDS than any other racial or ethnic group. In 2006, in order to combat the spread of HIV and AIDS in Florida, the Bureau of HIV/AIDS of the Florida Department of Health produced the widely distributed report entitled Silence is Death: The Crisis of HIV/AIDS in Florida's Black Communities. Of the top twenty counties with the highest rates of HIV/AIDS infection in Florida, Palm Beach County is the second highest for the rate of infection in the Black population; fifth highest in the rate of infection in the Hispanic population and eighth in the rate of infection in the white population. For the overall county population, Palm Beach County has the fifth highest rate of infection of all counties in the State of Florida.[7]

This prevalence rate varies by race and gender.[8] In Palm Beach County, the PLWHA prevalence rate per 100,000 population in 2005 was 297 for White males (i.e., 1 in 337); 2,494 for Black males (i.e., 1 in 40); 527 for Hispanic males (i.e., 1 in 190); 298 for males of other ethnicities (i.e., 1 in 336); 86 for White females (i.e., 1 in 1163); 2,076 for Black females (i.e., 1 in 48); 237 for Hispanic females (i.e., 1 in 422); and 196 for females of other ethnicities (i.e., 1 in 510). Thus, among Black males, the rate is 8 times higher than among White males. Among Black females, the rate is 24 times higher than among White females. The rate among Hispanic males is 2 times higher and among Hispanic females is 3 times higher than the rates among their White counterparts.[9]

The PLWHA prevalence rate also varies by geography. In 2004, the rate for the eastern, urban part of the county, which includes the cities of West Palm Beach, Lake Worth, Riviera Beach, Boynton Beach, and Delray Beach, was 500 per 100,000 (i.e., 1 in 200). In contrast, the rate in the western, rural part of the county, which encompasses Belle Glade, Pahokee, South Bay, and Canal Point, was 2,347 per 100,000 (i.e., 1 in 43). Thus, the PLWHA rate in the western portion of the county is nearly 5 times greater than the rate in the eastern part of the county.[10]

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[5] Florida Department of Health, Bureau of HIV/AIDS Surveillance Section (2006). *Section 2 – Table 1b: Background Data Used for the Calculations of AIDS Prevalence, and HIV (Not AIDS) Prevalence (Excluding Department of Corrections).*
[6] Ibid.
[7] Florida, Department of Health, Bureau of HIV/AIDS (2006) Silence is Death: The Crisis of HIV/AIDS in Florida's Black Communities.
[8] Florida Department of Health, Bureau of HIV/AIDS Surveillance Section (2006). *HIV/AIDS Epidemoilogy, Palm Beach County.*
[9] Ibid.
[10] Lieb, S. (2005). *The Impact of HIV/AIDS on the Glades.* Florida Department of Health Bureau of HIV/AIDS.

a.i Epidemiology

The following data on AIDS incidence, AIDS prevalence, and HIV (not AIDS) prevalence are shown in **Attachment 3.**[11]

a.ii AIDS Incidence

AIDS incidence is defined as the number of new AIDS cases diagnosed during 2004 and 2005, as of 01/06/06. A total of 796 AIDS cases were diagnosed during this period. In regard to race/ethnicity, about two-thirds (61%) of the total was comprised of non-Hispanic Blacks; about one-fifth (21%) were non-Hispanic Whites, and 16% were Hispanics. About two-thirds (63%) of these cases were males. Almost all of these cases (99%) occurred among adults aged 20 and over, with 62% occurring among the 20-44 year age group. The adult/adolescent population (age 13+) constituted 793 (?) of the total 796 cases. Among this population, the most frequent exposure category was heterosexual (59%), followed by MSM (31%). IDU accounted for only 7% of the cases. Among the pediatric population (age 0-12), all 3 were in the exposure category of "mother with/at risk for HIV infection".

AIDS Prevalence Estimate

The AIDS prevalence estimate is defined as the number of reported AIDS cases plus 5% for unreported cases through 2005, as of 04/05/06. These data exclude cases within the Florida Department of Corrections. As of the above date, an estimated 4,474 people were living with AIDS in Palm Beach County. The racial/ethnic, gender, and age distributions closely mirror those of the AIDS incidence data. Two-thirds (66%) of the cases are non-Hispanic Blacks, 23% are non-Hispanic Whites, and 10% are Hispanics. About two-thirds (64%) are males, and 99% are adults aged 20+. However, opposite to the adult age distribution of AIDS incidence, AIDS prevalence is higher among older adults aged 45+ (54%) than younger adults aged 20-44 (44%). Of the total 4,474 cases, 4,435 are among adults and adolescents (age 13+). Again, the exposure categories mirror those of AIDS incidence. 57% of the cases are heterosexual, 28% are MSM, and 10% are IDU. Among the 39 pediatric cases, almost all (97%) were exposed due to a mother with/at risk for HIV infection.

HIV (Not AIDS) Prevalence Estimate

The HIV (not AIDS) prevalence estimate is for 2005, as of 04/05/06. This estimate is defined as the total PLWAH minus AIDS prevalence. The estimate is adjusted for underreporting PLWH (not AIDS) and includes those diagnosed but not reported. As of the above date, the estimated total of people living with HIV (not AIDS) in Palm Beach County was 6,459. Their demographic characteristics again mirror those described above. 64% of these cases are non-Hispanic Blacks, 24% are non-Hispanic Whites, and 10% are Hispanics. 58% are males. Almost all (99%) are adults age 20+. Somewhat more (54%) are in the younger age group (20-44 years) than the older group (age 45+; 45%). The most frequent exposure category is heterosexual (62%), followed by MSM (27%). Among the 35 pediatric cases, 98% were due to a mother with/at risk for HIV infection.

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[11] Florida Department of Health, Bureau of HIV/AIDS Surveillance Section (2006). *Table 1: AIDS Incidence, AIDS Prevalence, and HIV (not AIDS) Prevalence.*

Summary of Incidence and Prevalence

As seen from the above data, the HIV-infected population in Palm Beach County consists primarily of adults (age 20+) Blacks, males, heterosexuals, and MSM. This is further illustrated by the following findings reported by the Florida Department of Health, Bureau of HIV/AIDS Surveillance Section[12]:

- In 2005, Blacks accounted for 72% of reported AIDS cases, but only 14% of the county population.
- In 2005, Blacks are over-represented among AIDS cases, accounting for 56% of adult cases among men and 73% of adult cases among women.
- In 2005, Blacks are over-represented among HIV cases, accounting for 54% of adult cases among men and 68% of adult cases among women.
- Among Black males, the AIDS case rate is 13 times higher than among White males. Among Black females, the AIDS case rate is 26-fold greater than among White females. Hispanic male rates are 5 times higher and Hispanic female rates are 5 times higher than the rates among their White counterparts.
- Among Black males, the HIV case rate is 9 times higher than among white males. Among Black females, the HIV case rate is 17-fold greater than among White females. Hispanic male rates are 3 times higher and Hispanic female rates are 4 times higher than the rates among their white counterparts.
- HIV cases tend to be younger than AIDS cases: 19% of male HIV cases and 28% of female HIV cases in 2005 occurred among those aged 13-29, compared with only 12% of male AIDS cases and 13% of female AIDS cases in this age group. HIV cases tend to reflect more recent transmission than AIDS cases, and thus present a more current picture of the epidemic.
- Among male PLWHAs, MSM represents the highest risk for all races. White males have the smallest percentage of heterosexual contact cases.
- Among female PLWHAs, heterosexual contact is the majority risk for all races.

Incidence and Prevalence Trends Over Time

The following are notable changes in HIV/AIDS incidence and prevalence in Palm Beach County over time[13]:

Overall Trends in Palm Beach County

- The number of PLWA has steadily increased every year since 1986.
- However, the number of newly-diagnosed AIDS cases (incidence) has decreased from 759 in 1996 to 360 in 2005. Accordingly, the AIDS incidence rate per 100,000 population has decreased from 76.6 in 1996 to 28.2 in 2005. Increasingly, a diagnosis of AIDS reflects late diagnosis of HIV and limited access to treatment.
- HIV incidence has decreased from 552 (53.5 per 100,000 population) in 1998 to 397 (31.1 per 100,000 population) in 2005. Newly reported HIV cases have decreased each year.
- From 2003 to 2005, there was a decrease of 27% in HIV cases and a decrease of 19% in AIDS cases.

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[12] Florida Department of Health, Bureau of HIV/AIDS Surveillance Section (2006). *HIV/AIDS Epidemoilogy, Palm Beach County.*

[13] Ibid.

Gender Trends in Palm Beach County

- The relative ratio of males to females among adult AIDS cases has decreased over time. In 1996 the male to female ratio was 1.8 to 1, whereas in 2005 it was 1.5 to 1. This relative increase in female cases represents the changing face of the AIDS epidemic over time.
- The trend for HIV cases by sex is the opposite of that for AIDS cases. Recent trends in HIV transmission are best described by the HIV case data. In 1996 the male to female ratio was 1.2 to 1, whereas in 2005 it was 1.3 to 1. The relative increase in male HIV cases might be attributed to proportional increases in HIV transmission among MSM, which may influence future AIDS trends.

Racial/Ethnic Trends in Palm Beach County

- In absolute numbers, from 2000-2005, HIV cases among Blacks decreased by 30%, while increasing by 20% among Whites. The decreases among Blacks may correspond to some extent with recent targeted prevention, while the increases among Whites may be associated with recent increases in HIV transmission among White MSM.
- Hispanic AIDS cases increased from 3% in 1996 to 12% in 2005.

Combined Gender and Racial/Ethnic Trends in Palm Beach County

- For most of the past 10 years, Black males accounted for more than 50% of AIDS cases among men.
- For most of the past 10 years, Black women accounted for more than 70% of AIDS cases among women.
- The percent of Black male HIV cases has decreased from 66% in 1998 to 54% in 2005. Increases have been observed among both White and Hispanic male HIV cases over this same time period.
- Although the majority of HIV cases among women are Black, the percent of Black female HIV cases has decreased from 85% in 1998 to 67% in 2005. Increases have been observed among both White and Hispanic female HIV cases over this same time period.

Age Trends in Palm Beach County

- The percent of newly reported AIDS cases has shown increases among the 20-29 and 30-39 age groups over the past several years.
- The percent of newly reported HIV cases has shown increases among the 20-29 and 50+ age groups over the past several years.

Exposure Trends in Palm Beach County

- Among males, MSM is the predominant mode of exposure, and HIV/AIDS prevalence due to MSM increased the fastest between 1996 and 2005 among all the exposure categories.
- Among females, HIV/AIDS, the primary mode of exposure is heterosexual and it is increasing the fastest.
- From 2000-2005, MSM AIDS cases increased by 18%, while heterosexual male cases decreased by 59% and IDU male cases decreased 59%.
- From 2000-2005, MSM HIV cases increased by 61%, while heterosexual male cases decreased by 56% and IDU male cases decreased 40%.

Disproportionate Impact on Certain Populations

As indicated by the data above, incidence and prevalence rates vary significantly by race/ethnicity, gender, age, and mode of exposure. This is further illustrated in the following table:

Average HIV Incidence Rates per 100,000 population age 13+, 2003-2005

	Heterosexual		MSM	IDU	
	Males	Females	Males	Males	Females
White	5.4	17.2	62.9	7.0	6.5
Black	347.0	500.7	207.6	48.3	21.6
Hispanic	43.1	85.1	127.0	19.5	12.0

Source: Florida Department of Health Bureau of HIV/AIDS Surveillance Section[14]

Based on the above data, the various subgroups are ranked from highest to lowest rate as follows. The higher the rate, the larger the disproportionate impact, thus the higher the rank:

Ranking of Average HIV Incidence Rates per 100,000 population age 13+, 2003-2005

Rank	Population	Rate
1	BF-Hetero	500.7
2	BM-Hetero	347.0
3	B-MSM	207.6
4	H-MSM	127.0
5	HF-Hetero	85.1
6	W-MSM	62.9
7	BM-IDU	48.3
Rank	Population	Rate
8	HM-Hetero	43.1
9	BF-IDU	21.6
10	HM-IDU	19.5
11	WF-Hetero	17.2
12	HF-IDU	12.0
13	WM-IDU	7.0
14	WF-IDU	6.5
15	WM-Hetero	5.4

Source: Florida Department of Health Bureau of HIV/AIDS Surveillance Section[15]

In summary, based on HIV incidence in the last three years, the top six subpopulations most disproportionately affected are as follows: Black heterosexual females; Black heterosexual males; Black MSM; Hispanic MSM; Hispanic heterosexual females; and White MSM.

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[14] Florida Department of Health, Bureau of HIV/AIDS Surveillance Section (2006). *Priority Setting Tool for Florida's Prevention Plannng Group.*
[15] Ibid.

Furthermore, the following subpopulations experienced increases in HIV (regardless of current AIDS status) incidence between 2004 and 2005 (Attachment 3):[16]

- Black MSM (37.5% increase)
- White female IDU (267% increase)
- Black female IDU (100% increase)
- Female Haitian born (9% increase)
- White male youth ages 13-24 (150% increase)
- Black male youth ages 13-24 (27% increase)
- Black female youth ages 13-24 (33% increase)
- Hispanic female youth ages 13-24 (25% increase)
- White women ages 15-44 (47% increase)
- Black pediatric cases ages 0-12 (400% increase)

The following subpopulations experienced increases in AIDS incidence between 2004 and 2005 (Table 1a, Appendix A):[17]

- Black MSM (38% increase)
- Hispanic MSM (32% increase)
- Hispanic Male IDU (100% increase)
- Black male youth ages 13-24 (125% increase)
- White women ages 15-44 (33.3% increase)
- Hispanic women ages 15-44 (40% increase)

Some of the above-identified groups are ranked in the lower half of the HIV incidence rates shown in the preceding table. Thus, they are not presently experiencing a high disproportionate impact, yet are experiencing increases in HIV and AIDS incidence. This suggests that these subgroups represent new and emerging populations with HIV disease. Specifically, these new and emerging populations are:

- Hispanic male, White female, and Black female IDU
- White women ages 15-44
- White male youth ages 13-24
- Black pediatric cases ages 0-12

Finally, as noted earlier, there is a major disproportionate impact in HIV and AIDS prevalence rates in the western, rural part of the county, compared to the eastern, urban part. The demographic and exposure factors in these two regions differ as well, as illustrated in the following table:

[16] Florida Department of Health, Bureau of HIV/AIDS Surveillance Section (2006). *Section 2 – Table 1a: HIV and AIDS Incidence, HIV/AIDS Deaths (Excluding Department of Corrections)*

[17] Ibid.

Persons Living with AIDS as of 12/31/03[18]

Subgroup	Eastern Region N=3,399	Western Region N=611
Male	64%	59%
Female	35%	41%
White	29%	2%
Black	61%	94%
Hispanic	10%	4%
Other	1%	<1%
MSM	31%	8%
IDU	12%	5%
MSM/IDU	3%	2%
Heterosexual	52%	82%
Other	2%	3%

As the table shows, in the western compared to the eastern region, PLWHA have a higher percentage of females, a much higher percentage of Blacks, a much higher percentage of heterosexual exposure, and a much lower percentage of MSM exposure.

1.b Impact of Co-morbidities

This subsection addresses selected co-morbidities (tuberculosis; sexually transmitted diseases; hepatitis; substance abuse; and chronic mental illness) and economic characteristics (homelessness; lack of insurance; and poverty) and how they increase the cost and complexity of delivering care to persons living with HIV/AIDS in Palm Beach County. Additionally, the impact of the state Medicaid program and the Medicare program in covering PLWHA health care costs, trends in enrollment and benefits, and how Part A funds fill the gaps, are described.

Co-Morbidities and Economic Characteristics

The following narrative describes how both costs and the complexity of providing care to PLWHA in the West Palm Beach EMA are affected by co-morbidities and economic characteristics by comparing their rates in the general EMA population with their rates among PLWHA in the EMA. The quantitative data and data sources supporting this narrative are provided in Attachment 10.

The co-morbidity prevalence rates among the PLWHA population were computed by taking the number of PLWHA affected by the co-morbidity, dividing this by the total number of reported PLWHA in the EMA (6,833), and multiplying by 100,000. The co-morbidity prevalence rates among the general EMA population were computed by taking the number of EMA residents affected by the morbidity, dividing this by the total number of residents of the EMA in the relevant year and multiplying by 100,000. The economic characteristic prevalence rates for the both PLWHA population and the total EMA population were computed as percentages rather than rates per 100,000.

Percentage changes for both groups (PLWHA and general population) between 2004 and 2005 were computed by taking the number of affected persons in 2005, subtracting the number of affected persons in 2004, and dividing by the number of affected persons in 2004.

[18] Lieb, op cit.

Tuberculosis
In 2005, the tuberculosis rate among PLWHA in Palm Beach County was 44 per 100,000, compared to 7 per 100,000 for the general population. Thus the PLWHA rate was more than 6 times the general population rate.

Minority populations make up the majority (80.5%) of the total tuberculosis population, In 2005 Black, not Hispanic was 53.3% and Hispanic was 27.2% of the tuberculosis population. The tuberculosis rate among the total population and the PLWHA population declined between 2004 and 2005. The percentage change among PLWHA was –50%, a greater decline than that of the general population at –8%. The Black population was the only racial group in which the rate increased, from 23.3 to 25.0 between 2004 and 2005.

Tuberculosis adds to cost and complexity of care by requiring co-infected individuals to be hyper-vigilant about medical protocols and even requiring a period of quarantine from the general population. Temporary housing is provided, yet this is expensive and it then becomes difficult to place such an individual after the patient becomes eligible for alternate placement. In fact, when TB patients are non-compliant with medical protocols, they can be incarcerated and forced to adhere. In Palm Beach County, the main TB clinic is housed next to the main HIV clinic. This allows for easy access for these co-infected individuals. In addition, the Florida Department of Health funds A.G. Holley Hospital -the original and last remaining tuberculosis sanatorium in the country which continues to be dedicated to tuberculosis. Currently, this hospital has funding for only 50 beds while tuberculosis continues to be a challenge for our EMA due to the emergence of HIV, an increase in homelessness, drug addiction, immigration from areas with high rates of tuberculosis, continued transmission in institutional settings, and the emergence of drug-resistant strains.

Sexually Transmitted Diseases
The epidemic of sexually transmitted diseases (i.e., infectious syphilis, gonorrhea, and chlamydia) in Palm Beach County is of on-going concern. In 2005, the infectious syphilis rate among PLWHA in Palm Beach County was 132 per 100,000, compared to 2 per 100,000 for the general population. Thus the PLWHA rate is 66 times the general population rate. However, the infectious syphilis rate among PLWHA and minority populations declined by 18% while it increased by 25% among the general population between 2004 and 2005. In 2005, Black, not Hispanics accounted for 38.7% and Hispanics accounted for 12.9% of the total number of cases.

In 2005, the gonorrhea rate among PLWHA in Palm Beach County was 263 per 100,000, compared with 67 per 100,000 for the general population. Thus the PLWHA rate is nearly 4 times general population rate. Additionally, the gonorrhea rate among PLWHA increased by 63%, compared to an increase of 38% among the general population between 2004 and 2005. There was an increase among Blacks, not Hispanic from 66% in 2004 to 71.1% in 2005. The rate per 100,000 population for the same groups during the same period of time increased from 280.5 to 311.3. In 2005 the Black, not Hispanic population accounted for 71.7% of the total cases while Hispanics accounted for only 7.5% of the general population.

In 2005, the chlamydia rate among PLWHA in Palm Beach County was 293 per 100,000, compared to 172 per 100,000 for the general population. Thus the PLWHA rate is over 1-1/2 times the general population rate. The chlamydia rate among PLWHA declined by 5% while it

increased by 29% among the general population between 2004 and 2005. While the percentages and rates decreased among minority populations. these populations continue to be disproportionately impacted. In 2005, the Black , not Hispanic population accounted for 51.0% of the total cases while the Hispanic population accounted for 18.1% of the total cases.

Providing medical care for these individuals can be challenging as STDs compromise an already weakened immune system and create additional opportunities for infection. STDs are leading indicators of who may be at risk for HIV due to practicing unsafe sex. In relation to complexity, STDs increase the likelihood both of transmitting and acquiring HIV and inflate the cost of treating PLWHA. Reducing STDs may prevent much of the sexually transmitted HIV infection. There is a need for secondary prevention services in order to prevent these individuals from further transmitting HIV into the general population.

Hepatitis

In 2005, the rate of acute and/or chronic hepatitis among PLWHA in Palm Beach County was 3,644 per 100,000, compared to 115 per 100,000 for the general population. Thus the PLWHA rate is more than 30 times the general population rate. The hepatitis rate among PLWHA declined by only 4%, compared to a decline of 91% among the general population between 2004 and 2005. Hepatitis A and B continues to have a low impact on the minority populations. Black, not Hispanic was 20% and Hispanic was 0% of the total Hepatitis B cases in 2005. There were not any Hepatitis A cases among the Black, not Hispanic nor the Hispanic communities in 2005.

Intravenous drug use increases the risk of HIV/hepatitis co-infection. Because HIV diminishes the ability of the immune system to fight off infection, it speeds the rate of liver damage caused by hepatitis. This places the co-infected patient at a greater risk of cirrhosis, liver cancer, and liver failure than persons infected with HIV alone. This co-morbidity is expensive and complicated to treat. This co-infection adds to cost and complexity of care because treating hepatitis with medications such as Interferon, Ribavirin, combination Interferon/Reibavirin, and/or Pegylated Interferon is expensive and usually requires the liver to process two regimens of medications instead of one associated with HIV. This combination of therapies creates severe side effects and often requires the co-infected individual to interrupt HIV protocols or stop treatment for hepatitis. Because HIV anti-retroviral protocols tend to compromise liver functions, having hepatitis adds the additional strain to the already compromised immune system of PLWHA. It has been necessary for the CARE Council to advocate for payment from insurance companies and public agencies including Ryan White and prisons for patients with HIV who need treatment for hepatitis.

Intravenous Drug Use (IDU)

In 2005, the rate of intravenous drug use (i.e., IDU exposure category) among PLWHA in Palm Beach County was 17,869 per 100,000, compared to an estimated 451 per 100,000 for the general population in 2003 (latest date available). Thus the PLWHA rate is nearly 40 times the general population rate. The IDU exposure rate among PLWHA increased by 2% between 2004 and 2005. Percent change for the general population is unavailable as the data were collected at only one point in time (2003).

Intravenous drug use plays a significant role in the spread of HIV, either through sharing needles or unprotected sex. Treatment of PLWHA IDUs is complex and costly because neither the HIV

community nor the substance abuse community want to take ownership of this population, claiming that the co-morbidities of IDU and HIV are too difficult to treat and that the protocols of substance abuse treatment are incompatible with HIV treatment regimens.

Other Substance Abuse

In 2005, the rate of substance abuse other than IDU among PLWHA in Palm Beach County was 4,859 per 100,000, compared to an estimated 8,660 per 100,000 for the general population in 2004 (latest date available). Thus, interestingly, the PLWHA rate is approximately one-half the general population rate. However, the substance abuse rate among PLWHA increased by 60% between 2004 and 2005. Percent change for the general population is unavailable as the data were collected at only one point in time (2004).

Substance abuse interferes with an individual's ability to adhere to his/her treatment regimen and keep appointments. It may also divert financial resources needed for food, shelter and other basic human requirements to the purchase of alcohol and/or drugs. Thus, substance abuse impacts health outcomes and contributes to the cost of providing services for persons with HIV who have a substance abuse problem.

Chronic Mental Illness

In 2005, the rate of chronic mental illness among PLWHA in Palm Beach County was 512 per 100,000, compared to an estimated 9,040 per 100,000 for the general population in 2004 (latest date available). Thus, interestingly, the PLWHA rate is only approximately 5% the general population rate. However, the chronic mental illness rate among PLWHA increased by 315% between 2004 and 2005. Percent change for the general population is unavailable as the data were collected at only one point in time (2004).

The complexity of serving mental health clients is increased by HIV infection. HIV infection increases the burden of illness among individuals who are mentally ill, encumbers their quality of life, and shortens their life expectancy. Evidence increasingly suggests that treating mental illness or distress can improve survival and reduce the progression of HIV, not only in obvious ways like improving adherence and social support, but also through biochemical mechanisms that researchers are only beginning to understand. Depression has been found to be associated with worse outcome in HIV disease. There are growing indications that treatment of mental health conditions can make a significant positive difference in the progression and physical outcome of disease. Additionally, the cost and complexity of service delivery to chronically mentally ill PLWHA in Palm Beach County is further complicated by poverty, lack of insurance, a lack of education and a lack of affordable and safe housing for this vulnerable population.

Homelessness

In 2005, the rate of homelessness among PLWHA in Palm Beach County was 1.2% compared to .01% among the general population. Thus the PLWHA rate is approximately 10 times the general population rate. The homelessness rate among PLWHA increased by 6% between 2004 and 2005, while it decreased by 5% among the general population. Preliminary results of the Comprehensive Needs Assessment 2007-2010 are available. The table below displays the results of the homeless respondents by all respondents as well as all Black, Haitian and Hispanic/Latino respondents.

Preliminary Comprehensive Needs Assessment 2007-2010 Results	All Respondents n=400		All Black Respondents n=265		Haitian Respondents n=75		Hispanic/Latino Respondents n=44	
	#	%	#	%	#	%	#	%
Homeless	30	7.5%	22	8.3%	0	0.0%	3	6.8%

In Palm Beach County, homelessness and HIV are not confined to urban populations. The prevalence of HIV appears to be more frequent in our coastal metropolitan areas; however, there is evidence that both homelessness and HIV are widespread throughout our rural areas but are not as frequently reported. In fact, homelessness is not even defined the same way in rural areas as it is in urban areas. One of the complexities of tracking this vulnerable population is that they are transient. Many homeless PLWHA are not being treated and are not being targeted for services since they are difficult to identify. A higher cost for case managers, disease intervention specialists, and technicians is incurred because these are problem cases that require a great deal of time and close attention. Living with HIV spectrum disease and being homeless is a complicated situation. Maintenance of physical and emotional health is frequently ignored when food, clothing and shelter are of primary concern. Medical appointments are difficult to meet and maintaining complicated HIV drug therapies is a major challenge. Finally, homeless men and women often do not have available to them preventive measures used with other populations who are at risk for HIV. Shelters, food kitchens, and health clinics are model centers for HIV prevention; however, insufficient resources in Palm Beach County limit health education to the homeless and other interventions that others receive. Individuals who are homeless have limited access to health care. Such individuals are vulnerable to increased morbidity and mortality since they lack the care they need. Some barriers to access HIV-related health care in Palm Beach County for the homeless are: lack of health insurance, absence of financial resources, and lack of transportation.

Lack of Insurance
The number of uninsured PLWHA in Palm Beach County is unknown. However, it can be estimated based on their poverty levels. The 2004 Florida Health Insurance Study[19] found that 50% of Palm Beach County residents living at or below 100% of the poverty level were uninsured; 82% of those living between 101-200% of the poverty level were uninsured, and 17% of those living at or below 300% of the poverty level were uninsured. Applying these figures to the estimated PLWHA population at each of these poverty levels in 2005 results in an estimated 43% of PLWHA in Palm Beach County being without insurance coverage (including Medicaid). In contrast, 19% of the general population was estimated to be uninsured in 2004 (latest date available). Thus the PLWHA rate is more than double the general population rate. Percent change for either the PLWHA population or the general population is unavailable as the data were collected at only one point in time (2004).

The Florida Center for Medicaid and the Uninsured published Fact Sheet Number 1 in April, 2005 entitled Racial and Ethnic Disparities in Rates of Health Insurance Coverage. Looking at the 2004 Florida Health Insurance Study data, they noted that Hispanics had the highest rate of un-insurance (31.8%) of any racial or ethnic group, in part because they are more likely to be

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[19] Florida Agency for Health Care Administration, Office of Medicaid Research and Policy (2004). *Highlights from the Florida Health Insurance Study, Palm Beach County Augmentation.*

recent immigrants who do not qualify for Medicaid or to work for smaller firms that do not provide insurance coverage. Almost one-quarter of Florida's Blacks were uninsured (22.6%), compared with 14.3% of Non-Hispanic Whites. And a comparison of the 1999 and 2004 Florida Insurance Studies survey results indicate that un-insurance rates increased over the 5-year period.

Lack of health insurance, high deductibles, the price of prescription drugs and co-payments are barriers to accessing health care for many PLWHA. In Palm Beach County, there are several federal, state, and local programs to assist low-income people with the financial burdens of health care, but they do not come close to meeting the full need. Health care programs for the uninsured include: primary, preventive, specialty, AIDS treatment, prenatal, family-planning, pharmaceutical, labs, radiology, vision, dental, substance abuse, and mental health services. These are provided through the county health department and a network of Part A funded private doctors and community-based HIV medical providers.

While individuals with fee-for-service Medicaid have good health coverage, in some instances they have fewer choices than those with private insurance, especially in rural areas where many providers do not accept Medicaid. Fortunately, the providers in the EMA who tend to have the largest patient loads and most experience with HIV/AIDS do currently accept Medicaid; however, this is a tenuous alliance and is threatening to change.

Statewide, the numbers of HMOs have collapsed, leaving gaps in private insurance for much of the state's population. As the HMO crisis evolves, it is expected that more PLWHA will have difficulties securing and maintaining private insurance.

The Health Council of South administers the AIDS Insurance Continuation Program (AICP) for those diagnosed with AIDS or who are HIV-positive with symptoms and who, because of their illness, are unable to maintain their private health insurance coverage. The program makes direct payments of up to $650 per month to each client's employer or insurance company for the continuation of medical, dental, mental health and optical coverage. AICP also pays any fees associated with conversion of a COBRA policy to an individual policy or policy upgrades. The program also pays client co-payments and deductibles on an as needed basis. This program is funded through the Florida Department of Health.

The State of Florida also administers the AIDS Drug Assistance Program (ADAP). ADAP is intended to help HIV-positive people stay healthy by assisting with the purchase of HIV prescription medications. ADAP provides HIV drug treatments for people who do not have private health insurance, do not qualify for Medicaid or are waiting for Medicaid eligibility and cannot afford to purchase the medications themselves.

Poverty
In 2005, an estimated 82% of PLWHA in Palm Beach County lived at or below 300% of the federal poverty level, compared to 46% of the general population. Thus the PLWHA rate is almost double the general population rate. The rate among PLWHA increased by 13% between 2004 and 2005, while the general population rate was unchanged.

Preliminary results from the Comprehensive Needs Assessment 2007-2010 comparing the Federal Poverty Level (FPL) of the respondents are summarized in the following table. Comparing these results to the data above suggest that the FPL may be increasing among

PLWHA. A higher percentage of Black, not Hispanic and Haitian populations are living at or below 100% of the FPL than total respondents.

Federal Poverty Level	All Respondents		All Black Respondents		Haitian Respondents		Hispanic/Latin Respondents	
	#	%	#	%	#	%	#	%
Below 100%	293	73.3%	218	82.3%	66	88.0%	29	65.9%
101% - 150%	39	9.8%	23	8.7%	6	8.0%	5	11.4%
151% - 200%	30	7.5%	10	3.8%	1	1.3%	5	11.4%
201% - 250%	7	1.8%	3	1.1%	0	0.0%	1	2.3%
251% - 300%	4	1.0%	1	0.4%	0	0.0%	0	0.0%
Over 300%	17	4.3%	5	1.9%	1	1.3%	2	4.5%
No response	10	2.5%	5	1.9%	1	1.3%	2	4.5%
Total	400	100.0%	265	100.0%	75	100.0%	44	100.0%

PLWHA living at, near, or below poverty are often marginalized and distrustful of governmental service systems and tend to be less educated or illiterate and less likely to follow treatment regimens than others who are not living at, near, or below poverty. In order to be successful in achieving health outcomes, individuals living in poverty require intensive follow-up, adherence counseling and treatment education. This presupposes they place a personal value on their own health, which in many cases, they do not; or at best, their health needs are a low priority. Higher priority is placed on financial stability, housing, food, care of children and other family members, as well as other daily requirements and non-essentials. The stress these individuals place on the system is great and complex as linkages between a variety of services along the continuum are needed in order to effectively meet their needs.

In conclusion, PLWHA frequently have co-morbidities that are further complicated by low income, lack of insurance, and/or homelessness. These patients bring a multitude of costly life issues to the primary care provider's office and rightly expect these complicated factors to be included in the provision of quality clinical care.

Medicaid/Medicare Funding

This subsection describes the impact of the State Medicaid program and the federal Medicare program in covering PLWHA health care costs in Palm Beach County, including information on trends in enrollment and benefits, and how Ryan White Part A funds fill the gaps.

Medicaid

In 2005, 1,463 PLWHA in Palm Beach County received care through Medicaid. Of these, 746 (51%) were diagnosed with AIDS and 717 (49%) with HIV (not AIDS). 700 (48%) were male and 763 (52%) female. 970 (66%) were Black, 280 (19%) White, 94 (6%) Hispanic, and 119 (9%) other races/ethnicities.[20]

[20] Florida Department of Health, Bureau of HIV/AIDS Surveillance Section (2006). *EMA ADAP Medicaid by HIV AIDS Status.*

This is 13% of the total PLWHA population in the county. In 2004, the number of PLWHA receiving Medicaid was 2,277[21]; thus, the number of PLWHA receiving Medicaid has decreased by 36% between 2004 and 2005. In 2004 the total Medicaid benefits paid to PLWHA were $5,732,904, or $2518, per enrollee.[22]

Medicaid reforms are being implemented on both the state and federal levels. Many of the reforms will severely impact those who utilize or need to utilize Medicaid. The impact will be felt particularly hard by CARE Act funded programs in that clients' who fall off the Medicaid rolls will be seeking Ryan White funded services for health and medication.

New identification regulations require that nearly all applicants for Medicaid provide proof of Identification and U.S. Citizenship. Nearly every individual who indicates U. S. citizenship on an application must provide documentation of U.S. citizenship and identity to receive, or continue to receive, Medicaid. Self-declaration is no longer sufficient. All citizenship and identity documents must be original or copies certified by the issuing agency. This poses a barrier because the majority of Medicaid applicants are low income, cannot afford to pay for certified copies of their birth certificates or may not have birth records, cannot replace documents lost in hurricanes, and cannot afford to obtain state identification cards. Eligibility requirements have also been tightened by lowering the qualifying income level to the SSI level. Statewide in Florida, this will cause 77,000 to lose benefits. Immigrants who lose SSI benefits because of recent immigration reform have also reported being terminated from Medicaid even though they remain eligible for both food stamps and Medicaid.

HIV/AIDS medication seems to be largely untouched at this point, but non-HIV medications must be in the new Medicaid drug formulary. The prior authorization rule has a "fail first" feature: To be covered, some more costly mental health drugs must not only secure physician-requested prior authorization--but less expensive formulary-preferred drugs must be shown to have already failed for that patient.

Florida is currently rolling out privatization of Medicaid. It in effect creates a HMO-based Medicaid program. Though it is in its initial stages, concerns are being raised over lack of choice on behalf of patients, the need to change established health care providers because current ones may not be covered, limitations and caps on services and medications. In its first year of the pilot program implementation in Broward and Duval Counties, the lack of providers willing to participate in the pilot program has proven to be a major stumbling block even as the State prepares to roll the program out state-wide.

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[21] 2006 Ryan White Title I Application.
[22] Ibid.

Medicare
An estimated 8% of the county's PLWHA received Medicare in 2005[23]. It is presumed that most of these were receiving Medicaid due to disability, not to being age 65+.. In comparison, 2% of the county's general population received Medicare for disabilities in 2003 (latest date available)[24]. The estimated number of PLWHA receiving Medicare decreased by 5% between 2004 and 2005.[25]

Further data, including data on trends in benefits, are not available, as Medicare officials have informed us that matching their database with the State's HARS would cost several thousand dollars, and neither the local nor state governments have budgeted for this expenditure.

How Part A Funds Fill the Gaps
As described above, an estimated 43% of the PLWHA population has no insurance, including Medicaid. Ryan White Part A funds fill the gaps in medical care for these PLWHA who have no private insurance and have been denied benefits from public sources such as Medicaid and the Palm Beach County Health Care District, a local taxing district. Since 82% of PLWHA in Palm Beach County live at or below 300% of the poverty level, these individuals likely would not be able to afford care if not for Part A funds.

c. HIV/AIDS Care Needs of Individuals Currently in Care
Populations Underrepresented in CARE Act-Funded Primary Medical Care
Underrepresented populations may be identified by comparing demographic characteristics of the PLWHA population in the county with the characteristics of PLWHA served by the CARE-Act funded system in the county. The following table shows these comparisons in relation to race/ethnicity, gender, and age:

Comparison of all PLWHA with PLWHA Served, Palm Beach County, 2005

RACE/ETHNICITY	PLWHA[26]	PLWHA Served[27]
White	24%	27%
Black	65%	58%
Hispanic	10%	9%
Asian/Pacific Islander	0%	0%
American Indian	0%	0%
Other/Unknown	1%	5%
GENDER	**PLWHA**	**PLWHA Served**
Male	61%	56%
Female	39%	43%
AGE (years)		
0-12	1%	2%
13-44	51%	51%
45+	48%	47%

[23] Treasure Coast Health Council (2006). *FACTORS Clients by Medical Payer Source through Calendar Year 2005.*
[24] Centers for Medicare and Medicaid Services (2003). *Medicare County Enrollment.*
[25] Treasure Coast Health Council (2005, 2006). *FACTORS Clients by Medical Payer Source through Calendar Years 2004, 2005.*

[26] Florida Department of Health, Bureau of HIV/AIDS Surveillance Section (2006). *Epidemiological Profile, Palm Beach County.*
[27] Palm Beach County Department of Community Services (2006). 2005 Palm Beach County CARE Act Data Report (CADR).

The demographic characteristics of the PLWHA population in the county were described earlier. The demographic characteristics of PLWHA served by the CARE-Act funded system are obtained from the county's 2005 CARE Act Data Report. The latter figures may include duplicated numbers as they are based on totals from individual agencies. Nonetheless, these figures provide a reasonable estimate of the demographics of the PLWHA served. As seen in the table above, the demographic characteristics of the PLWHA population and the PLWHA served are very similar, with the exception of Blacks and males. Blacks comprise 65% of the PLWHA population, but 58% of the PLWHA served. Males comprise 61% of the PLWHA, but 56% of the PLWHA served. These figures suggest that these populations may be underserved.

In order to reach the Haitian population in Palm Beach County, collaboration with non-Ryan White service providers is necessary. The Sickle Cell Foundation is in its fourth year of operation with their Haitian Outreach Program that consists of one-to-one outreach, workshops/seminars and a close working relationship with the local Creole-language radio station. According to Joseph M. Bernadel, Founder of the Toussaint L'ouverture High School for the Arts and Social Justice, there are approximately 80,000 or more Haitian persons residing in Palm Beach County. Many speak no English, 55% are illiterate in their own language of Creole, and 30-50% lack legal documentation which creates fear to participate in government-sponsored programs. Cultural barriers include the lack of trust of western medicine and fear of social stigma of the Haitian community resulting from categorizing public health statistics by ethnicity (i.e. very high numbers of disease among the Haitian population may result in public humiliation of their community or the conclusion that "Haitians are disease ridden"). Therefore, developing working relationships with non-Ryan White providers is critical in reaching this underserved population.

Estimated Service Gaps

The Palm Beach County CARE Council conducted an interim PLWHA survey in the summer of 2006, while developing a revised Comprehensive Needs Assessment for 2007-2010.[28] Additionally, preliminary results from the Comprehensive Needs Assessment 2007-2010 are now available and will be included below to complement the results from the PLWHA Survey 2006. The PLWHA Survey 2006 utilized a survey instrument similar to that which was used in the 2000 & 2003 Comprehensive Needs Assessments. Service categories specified in the survey were consistent with those used by the planning council and HRSA to promote consistency of the data and subsequent analysis.

Using an on-line data collection tool, the survey instrument was posted on the CARE Council's website. PLWHA were encouraged to respond to the survey questions directly on the website, or complete the survey on a paper copy. The paper surveys were subsequently entered into the website database. Surveys were collected from June 7, 2006 through July 28, 2006.

Because the target group is known to be relatively reticent about disclosing information relevant to the topic of HIV/AIDS, respondents were recruited using variants of convenience sampling combined with purposive sampling strategies. Several HIV/AIDS service providers offered to conduct the surveys at their locations. The surveys were administered to PLWHAs by staff or the PLWHAs completed the surveys on their own with staff available to answer questions and

[28] Swanson, S. (2006). Survey of PLWHAs, August 2006. Riviera Beach, FL: Treasure Coast Health Council.

clarify directions as needed. In addition, 30% of the surveys were conducted in high-risk neighborhoods by a trained data collector who guided the PLWHAs through the survey. Surveys were also promoted and distributed at community forums and other appropriate venues. The surveys were distributed throughout the four main geographic areas of the county to ensure a broad and representative sample. Throughout the surveying process, aggregate demographic information of the respondents was monitored by the health planner to ensure a reflective sample. A total of 176 respondents completed the survey.

Data were collected using a 73-item survey instrument constructed to collect information from PLWHAs within Palm Beach County relating to service priorities and needs.
Survey respondents were asked to describe their level of utilization of the 31 service categories that the planning council prioritizes. The PLWHAs chose "need and use" if they utilize the service, "do not need" if they do not need the service, "need, can't get" to show gaps in services, and "can get, won't use" to show barriers in service utilization. In regard to primary medical care, reported levels of utilization by various demographic groups were as follows:

Primary Medical Care Utilization, Gaps, and Barriers

	Utilization (Need and Use)		Gaps (Need, Can't Get)		Barriers (Can Get, Won't Use)	
	N	%	N	%	N	%
All respondents (N=176)	124	71%	9	5%	2	1%
White Hetero (N=13)	9	69%	1	8%	0	0%
Black Hetero (N=93)	66	71%	4	4%	0	0%
Hispanic Hetero (N=10)	7	70%	1	10%	0	0%
White MSM (N=32)	28	88%	1	3%	0	0%
Black MSM (N=5)	2	40%	1	20%	0	0%
Hispanic MSM (N=7)	4	57%	5	14%	0	0%
White Women (N=8)	5	63%	1	13%	0	0%
Black Women (N=57)	36	64%	3	5%	1	2%
Hispanic Women (N=11)	6	54%	1	9%	0	0%
Black Hetero Men (N=40)	30	75%	1	3%	0	0%
White Hetero Women (N=7)	4	57%	1	14%	0	0%
Black Hetero Women (N=53)	36	68%	3	5%	0	0%
Hispanic Hetero Women (N=7)	5	71%	1	14%	0	0%
Rural Men (N=18)	124	71%	9	5%	2	1%
Rural Women (N=21)	17	81%	9	5%	2	1%

Source: Swanson, 2006.[29]

As seen in the table, only 5% of all respondents indicated that they need but can't get primary medical care, and only 1% indicated that they can get primary medical care but won't use it. The numbers for the various demographic subpopulations should be viewed with caution due to the small total in some cases. As seen in the table, the following populations exceeded the overall respondents in regard to primary medical care gaps (need, but can't get): White and Hispanic heterosexuals, Black and Hispanic MSM, White and Hispanic women, and White and Hispanic heterosexual women. In other words, these subpopulations appear to experience greater primary care gaps than the overall population, because their percentages of "need, but can't get" are higher than the whole sample's percentage of 5%.

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[29] Ibid.

In regard to all the service categories, the five most frequently ranked utilized services (need and use) for all respondents were:[30]
• Case Management (83%)
• Laboratory/Diagnostic Testing (80%)
• Dental Care (74%)
• Ambulatory Primary Outpatient Medical Care (71%)
• HIV Prevention (67%)

In regard to all service categories, the five services that were most frequently ranked by all respondents as "need, can't get", which shows gaps in services were:[31]
• Complementary Therapies (Massage) (35%)
• Complementary Therapies (Acupuncture/Reiki Therapies) (31%)
• Food (27%)
• Housing (20%)
• Direct Emergency Assistance (19%)

Overall the number of respondents that said they "can get, won't use" a service were very low. The five services most frequently ranked by respondents as 'can get, won't use', which shows barriers in services were:[32]
• Legal Services (6%)
• Day and Respite Care (5%)
• Clinical Trials (4%)
• Complementary Therapies (Massage) (4%)
• Complementary Therapies (Acupuncture and Reiki Therapy) (4%)
• Home Healthcare (4%)
• Substance Abuse Treatment-Outpatient (4%)

In summary, the PLWHA Survey 2006 suggests that overall, most respondents need and use primary medical care, although certain racial/ethnic, gender, and sexual orientation subpopulations report a greater primary medical care service gap than the overall population. Additionally, the largest service gaps overall were in complementary therapies and basic necessities (food, housing, emergency assistance).

Preliminary findings from the Comprehensive Needs Assessment 2007-2010 confirm similar findings of the PLWHA Survey 2006. The table below displays the top five prioritized service categories among all respondents as well as Black, Haitian and Hispanic/Latino respondents.

[30] Ibid.
[31] Ibid.
[32] Ibid.

Priorities of the Top Five Service Category	Prioritization All In Care Respondents n=252		Prioritization All Black In Care Respondents n=151		Prioritization Haitian In Care Respondents n=49		Prioritization Hispanic/Latino In Care Respondents n=37	
	#	%	#	%	#	%	#	%
Case Management	181	71.8%	116	76.8%	37	75.5%	16	43.2%
Housing	162	64.3%	100	66.2%			25	67.6%
Food Bank/Home Delivered Meals	151	59.9%	101	66.9%	19	38.8%	18	48.6%
Dental Care Services	134	53.2%	71	47.0%	24	49.0%	22	59.5%
Transportation	120	47.6%	66	43.7%			23	62.2%
HIV Prevention					23	46.9%		
Drug Reimbursement					20	40.8%		

The table below displays the most frequently identified services utilized, "need and use", among the 2007-2010 needs assessment respondents as well as the Black, Haitian and Hispanic/Latino respondents. The data below suggest that while medical services continue to be utilized at a high rate, several support services are also frequently utilized by respondents in care.

Top Utilized Service Categories	Utilization (Need and Use) All In Care Respondents n=252			Utilization (Need and Use) All Black In Care Respondents n=151			Utilization (Need and Use) Haitian In Care Respondents n=49			Utilization (Need and Use) Hispanic/Latino In Care Respondents n=37		
	rank	#	%	rank	#	%	rank	#	%	rank	#	%
Ambulatory/Primary Outpatient Medical Care	4	143	56.7%				1	38	77.6%	2	30	81.1%
Case Management	1	190	75.4%	2	108	71.5%	3	34	69.4%	1	33	89.2%
Clinical Trials							4	32	65.3%			
Counseling Other										4	16	43.2%
Dental Care Services	3	147	58.3%	3	90	59.6%						
HIV Prevention	5	132	52.4%	4	82	54.3%	2	35	71.4%	4	16	43.2%
Laboratory Diagnostic Testing	2	180	71.4%	1	109	72.2%				3	18	48.6%
Legal Services/Permanency							4	32	65.3%			
Peer Advocacy							3	34	69.4%			
Specialty Outpatient Medical Services							4	32	65.3%			
Transportation				5	80	53.0%						

The table below displays the most frequently identified service gaps, "need, can't get", among the 2007-2010 needs assessment respondents as well as the Black, Haitian and Hispanic/Latino respondents. While respondents identified gaps in several of the supportive services (housing, direct emergency assistance, food) presumably due to funding cuts, respondents also identified gaps in medical services, most notably drug reimbursement.

Top Service Category Gaps	Gaps (Need, Can't Get) All In Care Respondents n=252			Gaps (Need, Can't Get) All Black In Care Respondents n=151			Gaps (Need, Can't Get) Haitian In Care Respondents n=49			Gaps (Need, Can't Get) Hispanic/Latino In Care Respondents n=37		
	rank	#	%	rank	#	%	rank	#	%	rank	#	%
Complementary Therapies	4	69	27.4%	4	38	25.2%	4	10	20.4%			
Dental Care Services										1	23	62.2%
Direct Emergency Assistance	2	83	32.9%	2	43	28.5%	3	12	24.5%	3	21	56.8%
Drug Reimbursement	5	68	27.0%	5	36	23.8%	1	18	36.7%			
Food Bank/Home Delivered Meals	3	82	32.5%	1	46	30.5%	1	18	36.7%	3	21	56.8%
Health Insurance Continuation							2	13	26.5%			
Home Health Care Services										4	20	54.1%
Housing	1	85	33.7%	3	42	27.8%	4	10	20.4%	2	22	59.5%
Transportation										4	20	54.1%
Treatment Adherence							4	10	20.4%			
Vocational Rehabilitation							1	18	36.7%			

Table 1 in Attachment 11 displays the most frequently identified service barriers, "can get, won't use", among the 2007-2010 needs assessment respondents as well as the Black, Haitian and Hispanic/Latino respondents. Overall service barriers remain very low.

d. Unmet Need Estimate and Assessment

This section describes changes to Palm Beach County's Unmet Need estimate, including updates to the Unmet Need framework and how the framework has been used to assess and address Unmet Need.

This subsection describes the activities that Palm Beach County has implemented and is planning to implement assessment of unmet need. For completed activities, the findings are summarized, including determination of the demographics and location of people who know their HIV status and are not in care; assessment of service needs, gaps, and barriers to people not in care; efforts to find people not in care and get them into primary care; and use of the results of the Unmet

Need Framework in planning and decision making about priorities, resource allocations, and the system of care.

Demographics of People Who Know Their HIV Status and Are Not in Care

The usual way to determine the demographics of people out of care is to subtract data on people in care from the entire PLWHA population demographics from HARS. However, because of incomplete HARS reporting in Florida, the State is not able to provide comprehensive data with demographics in people in care, to be subtracted from the total profile to calculate the number of people out of care. State data, which matches ADAP and Medicaid data with HARS where possible, contains only partial information on the met need population. If that partial information were subtracted from HARS to calculate data on the unmet need population, what would be left would *not* be people out of care, but a mixture of people in care and people out of care. Therefore, Mosaica has recommended that we provide a side-by-side comparison of the demographics of people *in* care via ADAP or Medicaid, versus *all* PLWHA, to infer what population groups seem most likely to be out of care. If the total PLWHA population has a greater percentage of a demographic group compared to the in care population, this suggests that that demographic group is *under-represented* in the *in-care* population and therefore *over-represented* in the *out-of-care* population. The following table shows this side-by-side comparison.

Demographic Comparison of PLWHA In Care vs. Total PLWHA

	PLWHA Known To Be Receiving Primary Medical Services via ADAP or Medicaid		Total PLWHA	
Race/Ethnicity	**Total=3,640**		**Total=8,746**	
	Number	**Percent**	**Number**	**Percent**
White, Not Hispanic	784	22%	2,084	24%
Black, Not Hispanic	2,386	66%	5,686	65%
Hispanic	422	12%	892	10%
Asian/Pacific Islander	6	0%	24	0%
American Indian	2	0%	1	0%
Not Specified/Other	40	1%	59	1%
Gender	**Total=3,640**		**Total=8,746**	
Male	2,072	57%	5,294	61%
Female	1,568	43%	3,452	39%
Current Age (Years)	**Total=3,640**		**Total=8,746**	
0-2	2	0%	0	0%
3-12	58	2%	58	1%
13-19	64	2%	102	1%
20-24	70	2%	189	2%
25-29	149	4%	430	5%
30-39	776	21%	2,036	23%
40-44	715	20%	1,696	19%
45-49	666	18%	1,563	18%
50-59	821	23%	1,832	21%
60+	320	9%	840	10%

Male Adult Exposure	Total=2,043		Total=7,104	
MSM	962	47%	2,371	33%
IDU	147	7%	584	8%
MSM/IDU	93	5%	188	3%
Heterosexual	808	40%	3,882	55%
Other	32	2%	80	1%
Female Adult Exposure	**Total=1,538**		**Total=3,419**	
IDU	181	12%	394	12%
Heterosexual	1,311	85%	2,953	86%
Other	45	3%	72	2%
Pediatric AIDS Exposure (Current ages 0-12)	**Total=59**		**Total=59**	
Mother with/at risk for HIV Infection	59	100%	58	98%
Risk Not Reported/Other	0	0%	1	2%

Source: Florida Department of Health, Bureau of HIV/AIDS, Surveillance Section (2006). Unmet Need Estimates.

As can be seen, the in-care and total PLWHA populations are very closely matched in regard to race/ethnicity, age, adult female exposure, and pediatric exposure. This suggests that there is no particular racial/ethnic group, age group, adult female exposure group, or pediatric exposure group that is *over-represented* in the *out-of-care* population.

The demographic characteristics in which there appear to be differences between the in-care population and the total PLWHA population are gender and male exposure.

In regard to gender, the percentages of in-care and total PLWHA are fairly close, although males may be slightly *over-represented* in the *out-of-care* population, since they represent 57% of the in-care population but 61% of the total PLWHA population.

In regard to male exposure categories, MSM appear to be *over-represented* in the *in-care* population: they comprise 47% of males in care, but 33% of all PLWHA males. In contrast, heterosexual males appear to be *over-represented* in the *out-of-care* population: they comprise 40% of males in care but 55% of all PLWHA males.

Location of People Who Know Their HIV Status and Are Not in Care

The location of people who know their HIV status and are not in care may be inferred in the same manner as the inference of demographics as described above. The following table shows a side-by-side comparison of the locations of PLWHA in care via ADAP or Medicaid, compared with the total PLWHA population. These data were obtained from available zip codes in HARS for the two respective populations (in care PLWHA and total PLWHA). Some zip codes were missing and others were outside Palm Beach County, creating reduced totals. Nonetheless, we believe these data accurately reflect the locations of the two populations.

Geographic Comparison of PLWHA In Care vs. Total PLWHA

	PLWHA Known To Be Receiving Primary Medical Services via ADAP or Medicaid		Total PLWHA	
	Total=2,403		Total=6,742	
City	#	%	#	%
Belle Glade	215	9%	639	9%
Boca Raton	96	4%	396	6%
Boynton Beach	223	9%	639	9%
Canal Point	8	0%	10	0%
Delray Beach	282	12%	963	14%
Jupiter	45	2%	88	1%
Lake Worth	375	16%	959	14%
Loxahatchee	16	1%	134	2%
Pahokee	66	3%	39	1%
Palm Beach	8	0%	25	0%
South Bay	33	1%	53	1%
West Palm Beach	1,036	43%	2,797	41%

Source: Florida Department of Health, Bureau of HIV/AIDS, Surveillance Section (2006). ***Living HIV/AIDS Cases, Palm Beach, by Zip Code; ADAP 2005 by Zip Code, Palm Beach; Medicaid 2005 by Zip Code, Palm Beach.***

As can be seen, the percentages of the PLWHA in care and the total PLWHA are very similar in all the cities. This suggests that *there are no* particular areas of the county where out-of-care PLWHA are *over-represented.* That is, PLWHA out of care appear to be proportionately dispersed across the county in relation to the dispersal of all PLWHA.

Assessment of Service Needs, Gaps, and Barriers to Care for People Not In Care

The service needs, gaps, and barriers to care for people not in care have been previously described in the Special Populations portion of the Demonstrated Need section. They include:

- Stigma.
- Complacency about HIV disease among young MSM.
- Need for more provision of secondary prevention among young MSM and IDU.
- Need for more outreach to MSM, particularly men of color.
- Need for more coordination between HIV service providers and substance abuse treatment providers to serve IDU and other substance abusers.
- Need for a programmatic component to specifically target MSM/IDU.
- The "down low" phenomenon, i.e., high stigmatization of homosexuality in the African American community.
- Need for more coordination between corrections and community HIV/AIDS care programs.
- Distrust of the care system among African Americans.
- Long waits at clinics.
- Difficult eligibility processes.
- Perceived poor or discriminatory treatment by clinic staff.
- Poverty.

- Insufficient comprehensiveness and capacity of the care system.
- Location of services at multiple sites that are difficult to get to.
- Unappealing atmosphere in care settings.
- Feelings of powerlessness.
- Placing other individual and family needs before the need for HIV/AIDS care.
- Language barriers for Haitians and Mayans.
- Literacy problems.
- Lack of transportation.
- Inability to leave work for medical appointments.
- Fear of arrest, detention, and deportation among documented and undocumented immigrants.
- Use of indigenous healing practices.
- Gender power disparities.
- National and cultural diversity among the Hispanic population.
- Seasonal, part-time, transient employment among foreign-born Hispanics.
- Large distances to clinics in the rural portion of the county.
- Lack of childcare.
- HIV/AIDS conspiracy beliefs.
- Lack of insurance.

Additional reasons for being out of care were found in the county's recently completed Special Project of National Significance, which was a study of Black women out of care, (described earlier in the Demonstrated Need section).[33] Many of these reasons seem likely to apply to other demographic groups as well. When asked why they were out of care, the respondents in the study reported that:

- Financial services are more important to them than medical services.
- They are not certain of what case management is.
- They do not want to have to abstain from drugs or speak to case managers to qualify for medical care.
- They can't get referrals.
- They can't figure out what to do, where to go, or how to get there.
- They are reluctant to take medicine because it makes them sick (side effects).
- They need to have other services in place (such as food, shelter, safety) before they even think about getting medical care.
- Some believe that they are "carriers" of HIV, but don't really have it.
- They don't think they need to go to care because they do not feel sick.
- Some believe that HIV is not a disease, but a curse or punishment, and they pray for healing.
- They prefer to use home remedies and faith healing.

[33] Palm Beach County HIV CARE Council (2005). *Care System Assessment Demonstration Project, Palm Beach County.*

Finally, the 2006 PLWHA Survey[34], also described in the Demonstrated Need section, also examined the reasons for PLWHA being out of care. The survey included 17 respondents who were out of care. When asked why they had not received medical care in the past 12 months, the respondents stated, as recorded the interviewer's notes:

- "Stigma that surrounds the illness" (Black female, eastern county)
- "She can't read that good. She had two children and needs help but doesn't want anyone to know that she is positive. She has a few friends that don't want to have anything to do with her. She don't want that and asked me not to tell anyone she is HIV positive." (Black female, eastern county)
- He just don't want to go. He said that he rather die than go to any clinic where HIV/AIDS people go. He said he's been positive since 2002. He said he don't want to have anything to do with HIV." (Black male, eastern county)
- "It's nobody's business but his." (Black MSM, eastern county)
- "Worry about people talking about me and feeling alone." (Black female, eastern county)
- "Too many people know me at the clinic. I don't want no one to know I have HIV." (Black male, eastern county)
- "She just moved back into town. She has to go back through the process. She says they made her go here and there to be denied for other programs in order to get her meds." (Hispanic female, eastern county)
- "I don't have medical insurance." (White female, western county)
- "I am in need of dental repair and care. However I am uninsured dentally. I need special eye care, but am uninsured for special eye care and treatment." (White MSM, eastern county)
- "I had an appointment with Medicaid on the 5th of the month, but I ended up being put into the hospital. When I called my caseworker back, I was told that I had to come into the office and wait, and maybe I would see the lady." (White, MSM, eastern county)
- "Child."(Black male, western county)
- "She only took the test and never went back for care. She said she don't feel sick at all. There's no need to go back for help right now." (Black female, eastern county)

Efforts to Find People Not in Care and Get Them Into Primary Care

Within the past five years, Palm Beach County has conducted two large Projects of National Significance addressing people out of care.[35] In both of these studies, we were successful in finding people out of care through the employment of PLWHA in care as research team members. These PLWHA in care were indigenous members of particular communities (e.g., Black rural community, Haitian eastern county community) who were very familiar with their communities. They found people out of care by going to locales where they knew such people were likely to be, as well as using their personal social networks. Although these were research studies and as such were not intended to get people into care, the same strategy is currently being used to achieve this purpose. Consequently, Palm Beach County's Comprehensive Plan for

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[34] Swanson, S. (2006). *Survey of PLWHAs, August 2006.* Riviera Beach, FL: Treasure Coast Health Council.
[35] [35] Palm Beach County HIV CARE Council (2005). *Care System Assessment Demonstration Project, Palm Beach County;* Palm Beach County HIV CARE Council (2001). *Rapid Assessment, Response, and Evaluation, Palm Beach County.*

2006-2009 has accomplished one of its objectives, to "Build an active network of PLWHA Peer Navigators." These PLWHA navigators are indigenous members of the communities who find the people out of care and follow through with getting them into care by helping them navigate the system of care.

Additionally, as indicated above in regard to the reasons why people are out of care, it is clear that the problem lies not only within those people but within the care system as well. Consequently, the County's Comprehensive Plan for 2006-2009 also includes the following objectives that are pertinent to these issues:

- Raise the level of public awareness regarding the needs of the HIV/AIDS community in a manner and language that the targeted populations find acceptable and appropriate.
- Improve linkages with local Counseling and Testing programs and facilities.
- Expand capacity of continuum of care to accommodate all PLWHAs that are aware of their status.
- Remove existing barriers to care particularly for hard-to-reach and marginalized populations.
- Enhance collaborations with non-Ryan White organizations and links to other funding sources.
- Enhance collaborations with HIV Outreach programs.
- Create a system of care that consumers and providers can navigate with ease in order to eliminate the duplication of services and eligibility processes as well as enhance efficiency, communication, and coordination.
- Strengthen system-wide confidentiality to increase community trust of the system. Require adherence to minimum standards regarding confidentiality for all providers. Promote consumer empowerment and education programs regarding rights and responsibilities, highlighting issues of confidentiality.
- Develop strategies to link treatment adherence protocols with substance abuse and mental health services and primary medical care.
- Develop a plan to assure that clients have the opportunity to choose their treatment adherence protocols and support the client's choices regardless of their decisions.
- Address the issue of stigma in a manner that is varied and appropriate for targeted populations. Develop social marketing techniques to be utilized at faith-based and community events that are culturally appropriate and palatable to the communities.
- Identify and work with people in their neighborhoods to devise outreach models and care maintenance interventions that are congruent with that community's beliefs, practices, and behaviors.

Since these strategies have recently been implemented, their results are not yet known. In the future, we will continue to find people out of care and bring them into care by focusing on four categories of people not in care:

- Newly diagnosed, reached through collaboration with prevention and testing sites.
- Receiving other HIV/AIDS services but not primary care, identified through support service providers.
- Formerly in care, known to primary care providers and payers.

- Never in care, who likely have co-occurring conditions such as substance use, mental health issues, and homelessness, or other barriers such as linguistic barriers and lack of transportation.

We will also continue to find people out of care in various venues such as:

- HIV counseling and testing sites
- Emergency rooms
- Substance abuse treatment programs
- Detoxification programs
- Adult correctional facilities and juvenile detention facilities
- STD clinics
- Mental health programs
- Homeless shelters
- Food banks
- Ministries

Use of the Results of the Unmet Need Framework in Planning and Decision Making about Priorities, Resource Allocations, and the System of Care

As stated previously, many of the inhabitants of Palm Beach County are immigrants from non-English speaking countries and the language differences are a barrier to access to health care for many. According to the 2000 Census, 10.3% of Floridians are Limited English Proficient (LEP), a 61% increase over the 1990 census. In parts of Palm Beach County, the figures are even higher: 28% of the residents of Lake Worth and 24% of those residing in Belle Glade are considered LEP. The primary languages spoken by the LEP residents in Palm Beach County are Spanish and Haitian-Creole, along with several Mayan languages. In 2004, the Palm Beach County Health Department reported that 43% of the patients visiting the clinics in Belle Glade and West Palm Beach were best served by a language other than English.

Unfortunately, local hospitals and clinics do not employ dedicated staff interpreters and there is no comprehensive system for the provision of language services. In 2005, a local coalition decided to improve access to care through the creation of what they called the "Language Access Program" (LAP). This coalition, known as the Palm Beach County Community Health Alliance, includes hospital administrators; university officials; not-for-profit agency directors; county government; private foundations; physician networks; free clinics; the state's Medicaid program and others. Through LAP, they created a program that addressed the language and cultural barriers that impacted access to quality health care. The LAP staff trained a core group of people in professional interpretation skills and culturally competency, in addition to researching "best practices" and models from around the country. Since the program's beginning, the LAP staff has trained 124 interpreters, through an internationally recognized 40-hour training program, and provided continuing bimonthly education workshops to trained interpreters. More than 600 providers participated in the various presentations and several of the Ryan White funded service providers have been participating in the trainings. Palm Beach County looks forward to greater improvement in access to quality healthcare as all involved continue to work together to reduce language and cultural barriers.

The Palm Beach County HIV CARE Council directly uses the unmet need estimates in its planning activities. As described above, many of the objectives in the current comprehensive plan relate directly to finding people out of care and bringing them into care. These objectives then lead directly to the development of priorities. Finally, the priorities, together with the number of people in care and the unmet need estimate, dictate the allocation of resources.

d.i Unmet Need Estimate (Framework)
A copy of the Unmet Need Framework is provided **in Attachment 4.** The Unmet Need Framework Table shows that in Palm Beach County in 2005:

- There were an estimated 4,474 persons living with AIDS. Of these, an estimated 2,966 (66%) received the specified HIV primary medical care services, and an estimated 1,507 (34%) did not.
- There were an estimated 4,274 persons living with HIV (not AIDS) who were aware of their HIV-positive status. Of these, an estimated 2,041 (48%) received the specified HIV primary medical care services, and an estimated 2,233 (52%) did not.
- In total, there were an estimated 8,748 persons living with HIV (not AIDS) and AIDS who were aware of their status. Of these, 5,008 (57%) received the specified HIV primary medical care services, and estimated 3,740 (43%) did not.

This subsection provides a narrative description of the methods used to develop the unmet need estimates, including revisions and updates based on feedback on the FY 2006 estimate; limitations and future plans to address them; reasons for choosing this method; and cross-title collaboration.

d.ii Methods Used to Develop Unmet Need Estimates
The following protocol describes the steps taken to identify the care patterns in the West Palm Beach EMA. The following information is also depicted in the table entitled "Assessment of in Care vs. Not in Care through the End of 2005" in Attachment 4. This table shows the detailed calculations that were used to produce the Unmet Need Framework Table for Palm Beach County.

- AIDS *Case* Prevalence is defined as the number of reported AIDS cases alive and reported through 12/31/05 as of 04/05/06.
- HIV *Case* Prevalence is defined as the number of reported HIV (not AIDS) cases alive and reported through 12/31/05 as of 04/05/06.
- HIV/AIDS *Case* Prevalence is defined as the number of reported AIDS cases and HIV (not AIDS) alive and reported through 12/31/05 as of 04/05/06.
- The HIV Prevalence Estimate includes reported PLWHA, ***plus*** an estimate of PLWHA diagnosed but **not** reported. Based on CDC's recent increase in the national HIV prevalence estimate, Florida increased their previous estimates of 100,000 for 2004 up to 125,000 for 2005, including the Department of Corrections (DOC). Therefore, the statewide HIV prevalence estimate (excluding DOC) for 2005 is 119,000. As of 04/05/06, there were approximately 75,000 PLWHA (excluding DOC) thus the formula to get to that estimate of 119,000 is to multiply the reported case count by a factor of 1.6).
- The number of persons living with AIDS (PLWA) and ***aware: (letter A below)*** is defined as the number of reported AIDS Cases alive and reported through 12/31/05, as of

04/05/06, plus 5%, to account for unreported AIDS cases. (AIDS Cases / 0.95). Florida has a very timely and complete reporting system. It is assumed that all AIDS cases are aware of their diagnosis.

- The number of persons living with HIV (not AIDS) (PLWH) and ***aware: (letter B below)*** is defined as the number of PLWHA (see below) minus the number of PLWA (above).
- PLWHA and ***Aware (letter C below).*** Florida assumes 80% of all PLWHA are Aware (HIV Estimate times 0.80). CDC estimates that 25% of all HIV-infected persons do *not* know their status. Florida has an aggressive HIV counseling and testing program, with a strong goal to get persons to know their HIV status. Therefore, it is believed that a smaller percentage of the PLWHAs in Florida do NOT know their HIV status compared with national estimates.
- PLWA and PLWH that are estimated to be ***Aware and IN care.*** These data were calculated by a combination of several steps:
    1. HARS case data of HIV/AIDS cases living and reported through 2005 were matched with the ADAP and Medicaid data. One single database was created that contains any HIV/AIDS case from HARS with at least one CD4 or Viral Load recorded in 2005 as well as the matched HARS/ADAP and HARS/Medicaid cases with either an Office Visit, RX or CD4 or Viral Load recorded in 2005, indicating that they received the specified HIV primary medical care service within a 12-month period as defined by HRSA. Geographic, demographic and risk data were also incorporated into the database.
    2. Analyses were performed on those cases who received the specified HIV primary medical care service in the 12 month period, to obtain the demographic and geographic data needed for the report to HRSA.
    3. Utilizing local resources, the West Palm Beach EMA estimated the percent of persons living with HIV (not AIDS) accessing care other than through Medicaid or ADAP (private care, Medicare, VA, Ryan White, etc.). It was assumed that the majority of persons living with AIDS are most likely in care via Medicaid or ADAP, therefore no further local estimates were made for this population. Since names from payer sources other than Medicaid and ADAP are not available for matching, the percent of the PLWH in care via these sources was added to the percent of those in care found via matches with Medicaid and ADAP. Two years ago, the West Palm Beach EMA estimated the percentage of PLWH in care via sources other than Medicaid and ADAP to be 32% of the PLWH aware population. Unfortunately, the key personnel who produced this estimate two years ago have since vacated their positions. Consequently, the institutional memory is somewhat impaired and we cannot describe in exact detail how this estimate was calculated. However, we can state that it was based on random chart reviews from local infectious disease physicians, the known number of Ryan White clients, and numbers provided by the VA and the Palm Beach County Health Care District, a local taxing district. Unfortunately, this estimate has not been updated in the past two years due to the personnel change; thus it is the best estimate we have at this time. In the coming year, we intend to revise and improve this local estimate

using one or more of the methods described below under "Future Plans for Improving Unmet Need Estimates: Local Estimates."

Using the above input data and estimates; we are able to generate EMA level data to estimate individual local care patterns using the HRSA formula.

A. **PLWA, AIDS Prevalence (Living) and Aware for a recent time period:**
   (Data Source is HARS). As defined above.
B. **PLWH, HIV (not AIDS) Prevalence (Living) and Aware for a recent time period:**
   (Data Source is HARS). As defined above.
   PLWHA Prevalence (Living) and Aware for a recent time period:
   (Data Source is HARS). As defined above.
C. **Number of PLWA who received the specified HIV primary medical care services in a 12-month period.** &
D. **Number of PLWH who received the specified HIV primary medical care services in a 12-month period.** (Data Source is HARS, ADAP, Medicaid, and local primary care resources).
   To calculate the numbers for both **D&E**:
   These estimates are based on the findings of a documented RX, CD4 or viral load as defined by HRSA and found by matching the HARS, ADAP and Medicaid databases. Assuming that the in-care patterns for the reported cases are similar to the care patterns of the unreported cases final numbers will be inflated to reflect the diagnosed but unreported cases.
E. **Number of PLWHA who received the specified HIV primary medical care services in a 12-month period.**
F. **Number of PLWA who DID NOT receive the specified HIV primary medical care services in a 12-month period.** These numbers were calculated by subtracting the PLWA aware and in care (C above) from the total PLWA aware (A above).
G. **Number of PLWH who DID NOT receive the specified HIV primary medical care services in a 12-month period.** These numbers were calculated by subtracting the PLWH aware and in care (D above) from the total PLWH aware (B above).
H. **Total of PLWHA who DID NOT receive the specified HIV primary medical care services in a 12-month period.** This total was calculated by adding the PLWA aware and NOT in care (E above) to the total of PLWH aware and NOT in care (F above).

Limitations

Although the HIV/AIDS Reporting System (HARS) data was utilized as one of the primary tools for estimating unmet need, it must be noted that there are limitations to the data in HARS. HIV cases were not reportable in Florida until July 1, 1997. HIV reporting is not retroactive; the report is limited to HIV confirmatory tests performed in a confidential setting since that time and only via diagnostic HIV tests (i.e., Western Blot or IFA). Therefore, HIV (not AIDS) cases with diagnostic dates prior to 07/1997 are not reportable. Viral loads and CD4 counts became reportable July 1, 2005; at the same time that retroactive HIV infection reporting became law. Thus both the HIV data and all laboratory data (Viral Loads and CD4s) for 2005 are incomplete. As of 11/20/06, all HIV viral tests and CD4 tests are now reportable, and the results may be available later this year.

Staffing is a limitation to having all of the CD4 and viral loads entered into HARS. Limited funds for data entry staff force the prioritizing of data entry of new cases or updates from HIV to AIDS into HARS (and an in-house laboratory database) over updating viral loads or CD4s that have no impact on the HIV or AIDS diagnosis. A new laboratory database is currently under construction and the process of electronic lab reporting is expected to be implemented within the next few years. This will improve data reporting of CD4 and viral load results, as it will eliminate much of the manual data entry currently required to update cases in HARS and/or the laboratory database with these data.

Even though the HIV reporting database is not complete at the present time, Florida has adjusted its methodology this year to perform a match with ADAP and HARS to assess which of the living and reported HIV/AIDS cases had at least one ADAP service (RX and/or lab as defined by the Framework) in 2005. Additionally, Florida's Department of Health collaborated with the Agency for Health Care Administration to finalize a legal agreement, which allowed access to a database with names and other key variables of Medicaid cases who received the specified HIV primary medical care services in the most recent 12-month period as defined by the Framework. These data were used to match against those living cases from the HARS database.

Thus the in-care data are a combination of some labs (Viral Loads/CD4s) entered in HARS (~12% of living cases), matched data with HARS, ADAP and Medicaid, and adjustments based on local estimates of people in care through other funding sources (e.g. private, VA, Medicare). Although this methodology differs from what would be ideal according to Mosaica (the technical assistance contractor for unmet need for the Federal Ryan White Program), it is closer to approaching that "gold standard" of estimating in care patterns of persons living and aware with HIV (not AIDS) (PLWH) and AIDS (PLWA). Furthermore, as requested by HRSA and Mosaica, Florida's methodology identifies different in-care patterns by demographic and risk groups for those data "known to be in care". In the future, as more complete client-specific in-care data becomes available, data for those PLWA (aware) but not-in care will be generated. Finally, as noted earlier, due to staff departures in the West Palm Beach EMA, the local estimate of people in care through sources other than Medicaid and ADAP was produced two years ago and its exact computation methods are unknown.

Future Plans for Improving Unmet Need Estimates

Estimates Produced for the EMA by the State

The estimates produced by the Florida Department of Health, Bureau of HIV/AIDS for all EMAs in the state are based on HARS data matched with Medicaid and ADAP data. The plans to improve these estimates are:

- Continue to re-evaluate the entire step-by-step process of calculating the unmet need in order to provide the most accurate area-specific data.
- Continue to incorporate matched data between HARS and ADAP and HARS and Medicaid in the methodology to ensure complete in-care data.
- Evaluate the completion of HARS data for use in more steps of this process of calculating unmet need.

- Evaluate the use of the out of state database (currently under construction) in this process. This database tracks cases who have moved to Florida for care, but are reported in another state, thus not in our HARS database.
- Incorporate the laboratory reporting database into the methodology next year. Electronic lab reporting is currently being established and should be in place within the next few years.

EMA Local Estimates

Estimates produced at the local level by the West Palm Beach EMA supplement those produced by the State. These are estimates of the number of persons living with AIDS and persons living with HIV (not AIDS) who are in care paid for by sources other than Medicaid or ADAP, that is, private insurance, Medicare, VA, Ryan White, etc. In the coming year, Palm Beach County will improve these local estimates by employing one or more of the following methods:

- Use State or local hospital discharge data to get an estimate of the percentage of people with HIV/AIDS who were discharged from the hospital during a specified 12-month period and have private insurance.
- Work with major insurance companies to get data on the number of clients with HIV and AIDS (preferably separately) who received anti-retrovirals or CD4 or viral load tests paid for through their insurance.
- Obtain data on the percentages of people with HIV/non-AIDS and with AIDS who are in care and have private insurance from providers that serve a mix of people with private and public funding. Use chart reviews to determine the payer mix, if the provider is Ryan White funded.
- Obtain data from labs that conduct viral load/CD4 testing regarding the percent of all lab tests paid for by private sources, using payer codes.

Reasons for Using the Methodology to Estimate Unmet Need

We acknowledge the limitations of the data on which these estimates are based. At present, the biggest assumption we are making is that those reported cases in HARS, ADAP and/or Medicaid for which there is a documented medical visit, RX, CD4 or viral load (as defined by HRSA) plus the local estimates of those in care via other sources are representative of those HIV/AIDS cases that are not yet reported in HARS. Nonetheless, we feel the balance of the data and assumptions are fairly robust to error and bias. Each year, Florida and Palm Beach County will strive to improve this methodology for calculating unmet need until more accurate in-care data is available via HARS and other matched databases.

Florida provides timely and comprehensive breakdowns of the HIV and AIDS cases by current age group for all of the prevalence data. Historically, Florida's estimates of prevalent AIDS and HIV (not AIDS) cases and their geographic and demographic breakdowns have been similar to those provided by the CDC, thus justifying Florida's estimates.

Cross-Title Collaboration

Data used to generate the unmet need estimates (HARS, ADAP, & Medicaid) are usually generated by the state and disseminated to the 6 EMAs and the 13 Part B consortia areas. These data are area (EMA or Consortium) specific and tailored to the needs of the grantees. The

incidence, prevalence and death data also include special population data, which further characterizes the local epidemic. Data generated by this date provides ample time for the local areas to write their local plans.

Preliminary finding of the Comprehensive Needs Assessment 2007-2010
Preliminary findings from the Comprehensive Needs Assessment 2007-2010 include data from PLWHAs who are out of care. The table below summarizes the respondents' situations. Haitian respondents reported having been recently diagnosed (46.2%) more often than the total population (21.6%). Latin/Hispanic respondents reported never being in care at a higher percentage (42.9%) than the total respondent population (35.1%).

Survey Question 23. What best describes your situation?

Situation	All Out of Care Respondents n=148		All Black Out Care Respondents n=114		Haitian Out Care Respondents n=26		Latin/Hispanic Out Care Respondents n=7	
	#	%	#	%	#	%	#	%
I have recently been diagnosed with HIV, and have not entered primary care.	32	21.6%	27	23.7%	12	46.2%	1	14.3%
I had been receiving medical care for HIV, but I stopped more than 12 months ago.	55	37.2%	45	39.5%	10	38.5%	3	42.9%
Never been in care	52	35.1%	33	28.9%	4	15.4%	3	42.9%
No Response	9	6.1%	9	7.9%	0	0.0%	0	0.0%
Total	148	100.0%	114	100.0%	26	100.0%	7	100.0%

Table 2 in Attachment 11 summarizes the reasons respondents most frequently identified for being out of care. The data suggest there are varying reasons among different populations for not being in care.

The following table summarizes the number of reasons the respondents identified for being out of care. This suggests that being out of care is a multifaceted and complex condition which will require multifaceted and complex remedies.

Number of Selected Reasons	All Out Care Respondents		All Black Out Care Respondents		Haitian Out Care Respondents		Latin/Hispanic Out Care Respondents	
	#	%	#	%	#	%	#	%
1	11	7.4%	9	7.9%	3	11.5%	0	0.0%
2 to 4	73	49.3%	57	50.0%	19	73.1%	2	28.6%
5 to 8	40	27.0%	27	23.7%	4	15.4%	4	57.1%
More than 8	14	9.5%	11	9.6%	0	0.0%	1	14.3%
No Response	10	6.8%	10	8.8%	0	0.0%	0	0.0%
Total	148	100.0%	114	100.0%	26	100.0%	7	100.0%

Respondents who were out of care were asked what services, other than medical services they needed in order to get into primary medical care. The table below summarizes their responses.

Survey Question 26. What services, other than medical care and medications, do you need to get into primary medical care? (check all that apply)

Services	All Out Care Respondents n=148		All Black Out Care Respondents n=114		Haitian Out Care Respondents n=26		Latin/Hispanic Out Care Respondents n=7	
	#	%	#	%	#	%	#	%
Financial Assistance	82	55.4%	60	52.6%			4	57.1%
Food	80	54.1%	60	52.6%	8	30.8%	5	71.4%
Housing	78	52.7%	63	55.3%	8	30.8%		
Case Management	76	51.4%	60	52.6%	13	50.0%		
Transportation	73	49.3%	57	50.0%	8	30.8%	4	57.1%
Dental Care					8	30.8%	4	57.1%
Legal Services					11	42.3%		

Again respondents tended to select several services, suggesting that their needs are multi-faceted and complex and in order to get all PLWHA in to primary medical care, funding is needed for all of the above supportive services. The table below displays the number of selected services needed.

Number of Selected Services Needed	All Out Care Respondents		All Black Out Care Respondents		Haitian Out Care Respondents		Latin/Hispanic Out Care Respondents	
	#	%	#	%	#	%	#	%
1	17	11.5%	12	10.5%	6	23.1%	1	14.3%
2 to 4	60	40.5%	43	37.7%	12	46.2%	3	42.9%
More than 4	57	38.5%	47	41.2%	5	19.2%	3	42.9%
No Response	14	9.5%	12	10.5%	3	11.5%	0	0.0%
Total	148	100.0%	114	100.0%	26	100.0%	7	100.0%

Table 3 in Attachment 11 displays the most frequently cited reasons respondents would enter care. The data suggests that there are varying reasons among different populations.

As summarized in the following table, most respondents (how many? What percent?) identified more than one reason that they would enter primary medical care.

Number of Selected Reasons to Enter Primary Medical Care	All Out Care Respondents		All Black Out Care Respondents		Haitian Out Care Respondents		Latin/Hispanic Out Care Respondents	
	#	%	#	%	#	%	#	%
1	36	24.3%	29	25.4%	9	34.6%	0	0.0%
2 to 4	76	51.4%	57	50.0%	12	46.2%	3	42.9%
5 to 8	17	11.5%	12	10.5%	0	0.0%	4	57.1%
More than 8	6	4.1%	5	4.4%	0	0.0%	0	0.0%
No Response	13	8.8%	11	9.6%	5	19.2%	0	0.0%
Total	148	100.0%	114	100.0%	26	100.0%	7	100.0%

2. PLANNING PROCESS, RESOURCE ALLOCATION AND FY 2007 MAI PLAN

a. Planned Allocations

Understanding the importance of assuring that the principles set out for the MAI funding were more comprehensive, as the intention of Congress was clear in the legislation, the CARE Council expanded the previous priority of case management.

In order to support the ability to access case management and other critical primary medical and specialty care services, the addition of drug reimbursement, dental, food, and transportation is essential to getting people into care and retaining them.

***a.i. The FY 2007 MAI funding allocation table* is located in Attachment 5.**

b. Description of Planning Resource Allocation Processes

The priority setting and allocation (P&A) process began in late February and concluded in late August. **A description of the items used and activities that took place to assist the planning council in determining the priorities and allocations for the FY 2007 and 2008 follow, Attachment 5.**

The planning council involved PLWHAs in the planning process to gather qualitative data through the following: Preliminary results of the Comprehensive Needs Assessment 2007-2010, Community forums, a PLWHA Survey, and a permanent representation of PLWHAs as members on the planning council and it's committees including the P&A Process as defined by the bylaws.

The preliminary data presented earlier in the proposal was presented to the Planning Council May 7, 2007. Based on that information the members prepared the proposed MAI 2007-2008 budget.

In addition, three public forums were held in three areas of the EMA that have been identified as being disproportionately impacted by HIV/ADS, the Belle Glade, Riviera Beach, and Delray

Beach area where Thirty percent (30%) of the participants identified themselves as being HIV positive the others in attendance did not report their HIV status. Black and Hispanics persons accounted for 48% of the participants. Recommendations from the forums and the committees included the following:

- Allocate the unrestricted funds from the outside contributors to Case Management and Direct Emergency Assistance
- Provider additional funding for:
  - Residential and outpatient substance abuse
  - Transportation
- Food Pantry
- Mental Health
- Direct Emergency Assistance
- More incentives in order the help get people into care
- Advertise services on billboards and bus benches
- Money for a Lunch & Learn or a support group for black women/black men and a Hispanic women and men group
- Funding for children's medication particularly those being dropped from Medicaid
- Support Groups with incentives of transportation and food and in locations within the community
- Serve the neediest first;
- Focus on life-saving and life-extending services;
- Increase prevention efforts;
- Increase accountability; and
- Increase flexibility.

As thoroughly discussed in the "Demonstrated Need" section of this application a client survey was conducted in June and July of 2006. The surveys were administered to PLWHAs by staff or the PLWHAs completed the surveys on their own with staff available to answer questions and clarify directions as needed. Surveys were conducted in all geographic regions of the EMA. In addition, 30% of the surveys were conducted in high-risk neighborhoods by a trained data collector who guided the PLWHAs through the survey. The survey report was also made available on the Care Council website, www.carecouncil.org .

In summary, the 2006 Client Survey suggests that overall most respondents need and use primary medical care and case management. The largest reported service gaps overall were in complementary therapies and basic necessities (food, housing, emergency assistance). Further demographic breakdown and the results of this survey that was completed by 176 PLWHAs who are the consumers of the HIV services in the EMA can be reviewed in the corresponding section in this application beginning on page 35.

The final method by which the PLWHAs participated in the P&A process is by serving a Planning Council through committee, including the P & A Committee or as an appointed member of the Planning Council.

The Health Planner developed a detailed work plan for the FY 2007 and 2008 P&A Process. During the final phase of the process, the Planner also included having a consultant from the

Academy of Educational Development (AED) visit to conduct a workshop -- *CARE Act Planning in a Changing Environment.* This all day work shop addressed changes in the HIV/AIDS environment, using information for decision making, roles as decision makers, and putting it all together for making recommendations for the Priorities and Allocations of Ryan White Funds in the EMA. Based on this workshop, the Planning Council chose to plan based on the Justice Paradigm of Utilitarianism (greatest good for the greatest number) and secondly with the Justice Paradigm of Compassion (assisting the neediest first). Furthermore, as a result of this workshop, the Planning Council also developed three main values that decision making is based on. These values include 1) Access to services for all who need services; 2) Compassion & Respect – treating all clients with respect and care; and 3) Accountability.

The following documents were also received and reviewed by Priorities &Allocations Committee members during the P&A Process for FY 07-08:

- P&A Committee Work Plan
- Allocation FY 2006-2007 across all five funding streams
- P&A Considerations and Recommendations for FY 07-08
- Priorities FY 07-08
- Flroida Department of Health, HIV and AIDS Reporting System Data 2005
- CADR Comparison Tables 2002-2005
- PLWHAs Survey Report
- PLWHAs Survey
- PLWHAs Survey Aggregated Results Report
- Unit Costs for FY05-06 & FY06-07
- Public Forum Demographic Breakout
- FACTORS data utilization report
- Funding Grids
- Part A HRSA's:
  - Section V Technical Assistance Papers, Priority Setting
  - Section VII Priority Setting and Resource Allocation
- Local Service Category Definitions
- HRSA's Service Category Definitions
- Reauthorization of the Ryan White CARE Act 2005 Update

Trends and changes in HIV/AIDS epidemiology data and the Unmet Need Framework were used in the P&A Process to identify and demonstrate how costs may increase in the upcoming year as more persons are targeted to have access to care. This quantitative data identified that were an estimated 4,474 persons living with AIDS. Of these, an estimated 2,966 (66%) received the specified HIV primary medical care services, and an estimated 1,507 (34%) did not. There were an estimated 4,274 persons living with HIV (not AIDS) who were aware of their HIV-positive status. Of these, an estimated 2,041 (48%) received the specified HIV primary medical care services, and an estimated 2,233 (52%) did not. In total, there were an estimated 8,748 persons living with HIV (not AIDS) and AIDS who were aware of their status. Of these, 5,008 (57%) received the specified HIV primary medical care services, and estimated 3,740 (43%) did not.

In response to the reporting of this data the planning council allocated significantly more money to all medical services, particularly outreach, treatment adherence, nurse care coordination, and transportation. Palm Beach County anticipates an increase in persons utilizing all medical service over the next fiscal year through efforts that are made in increasing access to underserved and special populations in the EMA.

Cost data were reviewed, across all five funding streams (Part A, Part B, HOPWA, State Revenue-Patient Care and Network). The planning council was presented with a funding worksheet that attempts to estimate costs for services over the next fiscal year by displaying the following information for each service category: actual number of clients served each year FY 2004 and 2005, estimated number of clients to be served FY 2007, mid point average of PLWH/A living in the EMA who need and use the service, FY 2006 defined, average cost per unit and average units per person FY 2005.

The planning council has addressed potential funding increases and decreases by preparing budgets for three circumstances including an increase, level or decrease in Part A funding. Part of the work plan that was distributed by the Health Planner includes reconvening after awards are made to respond to the award.

c. Coordination of Services and Funding Streams

Previously, in describing the continuum of care, the Coordinated Service Network was indicated as a partnership of funding organizations, planning organizations and service providers. The coordination of services and funding streams is the primary reason the Coordinated Service Network was formed. The funding members of the network: the Palm Beach County Board of County Commissioners is the grantee for Ryan White Part A; the Treasure Coast Health Council is the Lead Agency for Ryan White Part B, the Palm Beach County Health Department (Florida Department of Health) provides funds for medical and dental care through Patient Care and Network funds; the West Palm Beach City Commission is the Grantee for Housing Opportunities for People with AIDS (HOPWA); and the Palm Beach County Heath Care District (a local taxing district) administers ADAP funds through the operation of the County's pharmacy and also administers the State Children's Health Insurance Program.

These funding agencies convene annually, during the Priorities and Allocation process, to determine what services each will fund, based on their mission and amount of funding anticipated. The goal of this collaborative effort is to ensure that needs are met and services are not duplicated. After the funding agencies convene, a 'Funding Distribution' table is produced that shows the source of funds, the fiscal year for each agency (all agencies have different fiscal years), the anticipated amount of funding and the proposed services to be funded. This allows the Priorities and Allocations Committee to have a general picture of all services, the possible source of funds, the date funds will be available and the probable amount of funds. For example, Part A, due to funding constraints, is no longer going to fund Housing Services, the 'Funding Distribution' table displays the amount by housing service category that HOPWA is providing for PLWHAs. The Planning Council for the West Palm Beach EMA, plans for services and prioritizes and allocates funds for Part A, Part B, Palm Beach County Health Department (Florida Department of Health) which funds medical and dental care through Patient Care and Network funds, and Housing Opportunities for People Living with AIDS (HOPWA). All of the entities have agreed to this coordinated effort which helps to maximize the number of service

units provided, avoid duplicating service, and expand accessibility to services that are available. The grantees for Part A and B issue a common Request for Proposals during the contracting for services process.

The **Health Care District of Palm Beach County (HCD) administers the AIDS Drug Assistance Program in the EMA,** which is a local taxing district. The participation of the HCD in the ADAP State Program, the HCD is able to obtain the pharmaceuticals for free, for those Ryan White clients who qualify. Only a handling fee is charged to the Part A program. The HCD purchases the majority of its pharmaceuticals at the Public Health Services pricing schedule. That pricing schedule reflects the best price possible, unless it is free. The HCD uses the best cost containment strategies wherever possible.

There is **tremendous coordination with other State and Federal Resources** in the planning for the continuum of HIV care during the priority setting and allocation processes. The EMA has established several strategies in order to reduce duplication of services. Also the planning council has a Support Service Committee and a Medical Services Committee. The committees' membership includes local experts and consumers. The committees work to coordinate and communicate efforts within the system as well as countywide. Also, as discussed above the major funding members of our network participate in a coordinated effort to discuss services that each one funds, as well as, amount of funding anticipated. These activities help to maximize the number of service units provided, avoid duplicating service, and accessibility of services that are available.

Bringing people into care that know their status but are not presently in the system of HIV/AIDS primary medical care as well as keeping them in care is achieved in several ways. The MAI funding will work to assure that all people living with HIV/AIDS have access to the continuum of care and are supported in their effort to advocate on their behalf. The funded services will be widely disseminated and culturally appropriate.

The EMA ensures that CARE Act funds are the payer of last resort by having the case managers assist clients in applying for Healthcare District, Medicaid, Medicare, Social Security and Disability, and/or Veteran's Administration. Also **the Legal Aid Society of Palm Beach County assists clients in preserving their private health insurance as well as assisting clients in attaining governmental assistance, i.e. Medicaid, Medicare, Social Security and Disability.** Also, each Ryan White Part A client must sign a statement stating that they have applied for all other funding for HIV/AIDS services, but are not eligible. The services funded by the State and Federal resources are taken into consideration in planning for the continuum of HIV care and during the priority setting and allocation processes through an effort to coordinate services and funding streams.

In the area of prevention and early intervention, the EMA enjoys a good relationship with the local Community Planning Partnership (CPP-CDC Prevention Program). However, Prevention Planning funds were cut this year. This has resulted in the Palm Beach County Health Department taking over community planning activities these meetings are convened when necessary. Support staffs for the Planning Council and Part B are all employed by the same agency, the Treasure Coast Health Council.

The planning council has members that represent the entire spectrum of HIV/AIDS which includes the following: United Deliverance represents the jail linkage program, HIV testing site, early intervention, and CDC prevention programs; the Program Administrator of the Agency for Health Care Administration represents the State Medicaid program; State Children's Health Insurance Program (SCHIP) is represented by the Medical Officer and the Health Planner from the Health Care District of Palm Beach County; The Veteran's Affairs Program is in contact with the Council but is not currently directly involved; The City of West Palm Beach administers the HOPWA funding, they participate in the planning council meetings; Treasure the Children, as well as, Children Medical Services represent services for women and children; other state and local social service programs are represented including Legal Aid Society of Palm Beach County, Inc., COMPASS, and Comprehensive AIDS Program; several substance abuse and mental health treatment services agencies are involved with the planning council including Comprehensive Alcoholism Rehabilitation Program, Comprehensive Addiction and Education, Inc., Gratitude Guild, Inc., Oakwood Center and Drug Abuse Foundation.

The services funded by the State and Federal resources are taken into consideration by the Priorities and Allocations committee, as the committee is charged with considering all services for citizens within the EMA; prevention, early intervention, medical and support services prior to voting on the priorities and allocations.

The Palm Beach County Health Department, through contacts with local agencies funds several programs in the EMA these include: PBCHD currently has contracts with two local AIDS Service Organizations for Ryan White Part B Minority AIDS Initiative/Antiretroviral Treatment Access Study (ARTAS) activities. The ARTAS intervention addresses strategy three of the Advancing HIV Prevention (AHP) initiative: prevent new infections by working with HIV-infected persons and their partners.

- The ARTAS intervention is a brief, intense, research-based intervention designed to improve the follow-through of program participants with on-going medical and social services. Clients eligible for the program are recently diagnosed HIV-positive individuals and HIV-positive individuals who have been out of care for six months or longer

In addition to the ARTAS providers, two other AIDS Service Organizations, identify HIV-positive clients not in care, inform them about available treatment and services and assist them in the use of those services. These organizations work with targeted groups. One agency assists Men who have sex with Men through their Counseling, Testing and Linkage contract. The other agency serves women through their Targeted Outreach to Pregnant Women Act (TOPWA) contract.

The PBCHD has also entered into a partnership and collaboration with the University of Miami to promote health care and awareness in Palm Beach County. A memorandum of agreement reflects the desire to foster collaborative programs and initiatives in training, health care delivery and research. In addition, a contract with the University of Miami-School of Medicine (Dr. Clyde McCoy) to match Federal funding received by the school from the National Institute of Drug Abuse has been executed. The 'Administrative Supplement for the Study of Drug Abuse and HIV/AIDS' will initiate drug abuse and HIV/AIDS research infrastructure with the capacity

to design, test, adapt and evaluate culturally appropriate, evidence-based HIV prevention strategies and interventions among sexually active chronic substance abuse users in Belle Glade.

d. FY 2007 MAI Plan

The WPB EMA FY 2007 MAI Implementation Plan was developed to ensure access to care for minority persons in the current delivery system; ensure that persons are remaining in care; and to increase access for those persons not in care.

In accordance with HRSA, the ***preliminary results of the Comprehensive Needs Assessment 2007-2010, West Palm Beach EMA Comprehensive Plan 2006*** **and the** ***Palm Beach County HIV Care Council Needs Assessment 2003 – 2006***, **service priorities, demonstrated need data, and the unmet need data** are connected and serve as the road map for the service delivery system in the WPB EMA. The needs assessment and the comprehensive plan demonstrated service gaps in food, housing, direct emergency services, and complementary therapies. It also identified barriers in the following services legal services, day and respite care, complementary therapies, home health care, and outpatient substance abuse treatment. Services that were identified in these documents as the *most needed and used* services were case management, laboratory/diagnostic testing, ambulatory primary medical care, and HIV prevention. Using this information in the Priorities and Allocations process, the Care Council funded all of these identified gaps, barriers, and most needed service categories with the exception of complimentary therapies, which was not funded. The majority of the available funding has been allocated to the top six core services as (Primary medical care, HIV-related medications, mental health treatment, substance abuse treatment, oral health, and case management).

d.i. Table: FY 2007 Implementation Plan – Attachment 6

d.ii. Plan Narrative

The FY 2007 Implementation Plan will provide increased access to the HIV continuum of care in the WPB EMA for communities where HIV prevalence is increasing and in minority communities that are disproportionately impacted by HIV disease and to people who know their HIV status but are not in care. The Implementation Plan will continue to be enhanced through Core Medical Services including Medical Case Management, Drug Reimbursement and Oral Health Care (Dental). Support Services will include Food/home delivered meals and Medical Transportation. Core Medical Services and the support services are targeted to areas throughout the EMA according to "documented need with regard to demographics and epidemiology." The medical case management agencies keep client records of medical appointments, lab results and encourage clients to keep appointments, adhere to medications and as a goal prevent new infections. Agencies who serve the African-American, Haitian, Hispanic and other minority communities all have staff that reflects the demographics of the populations that they serve. This is to ensure that services are culturally and linguistically appropriate.

MAI funded services will be targeted **to communities where HIV prevalence is increasing in minority communities that are disproportionately impacted by HIV disease and people who know their status but are not in care.** Medical case managment services will identify people living with HIV and enroll them in care at an earlier state of illness. Medical case

management will also help bring persons back into care that may have dropped out of care for various reasons.

The **WPB Special Populations** consists of six (6) special populations, MSMs age 13+; Injection Drug Users (IDU) and MSM/IDU; Heterosexual Black (non-Haitian men); Women of Child Bearing Age (15-44); Haitian-Born Men and Women; and Hispanic Men and Women. These are the populations that are being addressed in MAI funded services. The needs of special populations are unique and varied so these services will be culturally sensitive and comprehensive to maintain them in medical care. Medical case management services will link these special populations to primary medical care and maintain these special populations in care.

The FY 2007 Implementation Plan encourages PLWHA to remain engaged in HIV primary medical and adhere to HIV treatment by providing services at four local county health departments, providing medical case management, including treatment adherence programs, assistance with funding for medications, and support services. Quality medical care is provided in accordance to the PHPS Guidelines at four County Health departments and several private physicians located throughout the county. Medical case management is a top priority of the Planning Council and is the key access point to HIV primary care and other support services. It is reported by outcome data that 98% of medical case managed clients are currently in primary medical care. Access to case management services is most often synonymous with access to primary medical care. Medical case management services are provided in Spanish for the Latino population and French Creole for the Haitian population. A response to the changing epidemic is increased funding for medication adherence. Part A funding that supports medication adherence services through the Local Supplemental Drug Program has been increased along with oral health care. The Haitian population needs adequate access to these services and there are various sites throughout Palm Beach County.

The medical transportation and food/home delivered meals are the two support services that were identified as having top priority through the Palm Beach County's needs assessments.

Geographical parity with the EMA is ensured through service providers that have multiple site locations throughout this EMA. This EMA has three health departments in four separate locations providing primary medical care, oral health care, laboratory and diagnostic testing, nurse care coordination, and treatment adherence. The case management agencies also have case managers on site at these locations to ensure access to care and other social services. Those locations comprise of the Coastal, Western and Southern communities of Palm Beach County. In addition 6 private physicians have contracts to provide medical services throughout the county so clients have a choice and there are 200 specialty doctors in the network that will accept referrals for Specialty Medical. Case management and the remaining support services are provided throughout the Coastal, Western and Southern areas of Palm Beach County. Culturally appropriate services are provided at all locations. Satisfaction surveys and the recent needs assessment surveys indicate that culturally sensitive services keep patients in Medical Care. The largest case management agency has five service centers located throughout the county (Belle Glade, Delray Beach, Riviera Beach, Lake Worth/Palm Springs, and Pahokee). Compass, Inc. has one service center located in West Palm Beach.

Cultural appropriateness is ensured through several objectives in the 2006 Comprehensive Plan. The competitive process to award service contracts requires potential vendors to demonstrate the ability to provide services in a culturally appropriate manner. The Planning Council has also completed and approved Standards of Care to ensure cultural and linguistic competency in all Ryan White Part A services.

The FY 2007 Implementation Plan is closely tied to Healthy People 2010, the Nations plan for healthy improvement. Healthy People 2010 has two major goals: (1) To increase the quality and years of a healthy life; and (2) Eliminate our country's health disparities. The Program consists of 28 focus areas and 467 objectives; one of the focus areas is HIV. The WPB EMA Part A FY 2007 is working towards the goals and objectives of *Healthy People 2010* through reducing barriers to care and maintaining individuals in care through such services as case management, mental health counseling, substance abuse treatment and legal assistance. Another main objective in *Healthy People 2010* is to reduce the disproportionate impact of HIV/AIDS among certain racial and ethnic groups. The WPB EMA has identified special populations, increased funding for medical case management services which includes treatment adherence, drug reimbursement and oral health care and is also funding medical transportation & food in support services. Currently, The Planning Council is also working toward ensuring that the goals of the EMA represent those in Health People 2010.

Women, Infants, Children and Youth (WICY): In accordance with the service priorities established by the Ryan White Part A Planning Council, all services directed to women, infants, children and youth (WICY) were funded. All services that are funded include primary medical care; case management and support services are all being utilized by WICY. In FY 2005, this EMA exceeded the Center for Disease Control and Prevention (CDC) percentage of 32.77% for WICY providing WICY with 40.76% with services.

MAI Funding
MAI funds will fund Medical Case Management, Oral Health Care, Drug Reimbursement and two needed support services. The dollars are used to reduce disparities and to improve access to care and primary medical services for populations that are disproportionately impacted communities of color and underserved communities through an expansion of Medical Case Management capacity. There is a specific focus on Haitian, African American populations and, within those populations, there is a focus on Women, Youth and Children.

3. IMPACT OF MAI SERVICES AND PLANNED CLIENT-LEVEL HEALTH OUTCOMES

MAI funds are distributed in the service category prioritized by the Planning Council to an existing community based minority agency. The funds were disbursed to one Case Management Agency: Comprehensive AIDS Program (CAP), which targets both Afro-American and Haitian populations.

Currently, CAP has six (6) offices/locations throughout Palm Beach County in and near the targeted communities with a documented history of providing services to both the Afro-American and Haitian populations that are culturally and linguistically appropriate. According to CAP, in 2006, 1015 Afro-Americans and 500 Haitians received case management services.

CAP is a minority-based organization that provides access to services to all people with HIV in Palm Beach County. A diverse Staff has been hired in order to make services accessible to the many different populations in the county. Additionally, special services are arranged for clients who are sight and/or hearing impaired, or have other barriers to accessing our services. Case managers frequently meet with clients in their homes, at health clinics, in hospitals, or in other settings that are convenient for clients who are unable to travel to CAP offices due to medical condition, physical disability, or lack of transportation.

As a minority-based organization, CAP responds to all persons with sensitivity to their cultural and linguistic orientations. As the population of Palm Beach County is racially and culturally diverse, CAP has proactively sought to make its services accessible and approachable to persons from not only African-American, but also Caribbean, Mexican, Guatemalan, Haitian and Anglo-American cultures. Most observably, this done by attracting and retaining staff from the ethnic and racial groups of the clients to be served and persons who speak the non-English languages of the clients. Sixty-five percent of CAP client services staff speak a language other than English, including 23 Spanish speakers and 33 Haitian Creole speakers, and 13 speakers of other languages, most notably French. Eighty-eight percent of CAP's staff is minority, with 21 African-Americans, 22 Haitians, and 15 Hispanics. Printed materials for clients regarding HIV/AIDS and the immune system is available in Creole, English and Spanish.

CAP has demonstrated the ability to attract clients and staff whose racial/ethnic characteristics approximate those of all persons diagnosed with AIDS in Palm Beach County as demonstrated in Table below. With approximately seventy-five percent of diagnosed AIDS cases in Palm Beach County being minority, CAP's client base is currently seventy-nine percent minority.

	All diagnosed HIV/AIDS PBC 12/30/2003	CAP Clients Year 2005	CAP Client Service Staff 2005
Black	65% (includes Haitian)	64%	65%
White	25%	21%	12%
Hispanic	10%	11%	23%
Other	<1%	4%	0%

Table 1. *Ethnicity among AIDS cases in Palm Beach County, CAP case management clients, and CAP Client Services staff. PBC data from FY2006 Title I Application from Palm Beach County to HRSA, October 2005*

The current MAI plan funds medical case management. Recently, the Planning Council recommended the following new program directions:

1. Medical Case Management
2. Drug Reimbursement
3. Dental
4. Food/Meals
5. Transportation

Currently MAI-funded services are evaluated based on multiple outcome levels to improve health outcomes.

a) initial outcome – increase enrollment in medical treatment or compliance for those individuals that are not currently receiving services;
b) intermediate outcome – increase CD4 count and decrease viral load levels for clients receiving and maintaining care under this initiative;
c) long-term outcome – increase health status and decrease opportunistic infections and hospitalization for the target population.

Additionally, CAP reports the following:

- Recruited minorities into the program through outreach including health fairs, testing and groups. Presentations are conducted as well to target minority including Haitians
- Tested about 2000 individuals a year
- Linked positive individuals to medical care and case management, followed by education staff for three to six months
- Linked more than 200 positive individuals to care through hospitals, prison, substance abuse, private physicians and substance abuse facilities
- Retained individuals through Lunch & Learn, reinforcement from case managers
- Provided 12 Peer Advocate Leaders (PAL) to assist with retention of individuals in care

4. CLINICAL QUALITY MANAGEMENT AND PROGRAM EVALUATION

The West Palm Beach Quality Management Program establishes a systematic approach to quality assessment and performance improvement for the West Palm Beach Ryan White Part A Program. The program meets the Ryan White Part A criteria established by the Health Resources and Services Administration (HRSA) for measuring and influencing quality of care and patient care improvement. The mission of the West Palm Beach Ryan White Part A Quality Management Program ensures equitable access to high-quality care and customer service, improvements in clinical outcomes, maximized collaboration of stakeholders and coordination of services, and complies with HRSA mandates. The West Palm Beach Quality Management Plan is designed to identify needs and gaps in service for all of the HIV/AIDS community of Palm Beach County; but also the specific client-level health care needs of the minority population.

As of April 30, 2007, there were a total of 7,107 cases of HIV/AIDS reported in Palm Beach County; this represents 6,987 adults and 120 pediatric cases. Of all cases reported, 42% of the rate of infection occurred in men having sex with men. The second largest segment has been heterosexual contact at 33% and injecting drug users at 7%. Men and women between the ages of 30 and 39 represent the largest percentage of HIV/AIDS cases at 35% of the total cases. HIV/AIDS cases by ethnicity represent approximately 64% black non-Hispanic, 24% white non-Hispanic and 11% Hispanic. With the disproportionate amount of minority HIV/AIDS cases in the patient care base, the West Palm Beach metropolitan service area has experienced a need to provide expanded ambulatory outpatient, pharmaceutical and oral health care comprehensive medical services to this target group. This includes enhancing, or supplementing, existing ambulatory outpatient, pharmaceutical and oral health care services in the West Palm Beach metropolitan service area.

The systematic approach for assessing and monitoring quality through the West Palm Beach Quality Management Program includes several continuous improvement processes; a pre-determined cycle of assessment, analysis and action for improvement and the development of a foundation of education and training. The West Palm Beach Plan and its activities are based on goals determined to be of need with the full collaboration of consumers, Ryan White Part A funded agencies, the Palm Beach County HIV CARE Council, and the Ryan White Part A Grantee Office.

The West Palm Beach Quality Management Program goals:

- Provide a common framework, language, and approach for quality improvement initiatives for providers across the EMA.
- Increase accountability and promote informed decisions making particularly in relation to how to use resources to achieve the best outcomes.
- Support and enable the Ryan White Planning Council's objectives to provide a Continuum of Care.
- Build capacity among the Ryan White Part A Grantee Office, Palm Beach County HIV CARE Council, and the Quality Management Committee to coordinate Quality Management (QM) efforts.
- Provide a way of linking population health indicators and outcomes with health systems performance indicators.

Core processes used in the development of the West Palm Beach Quality Management Plan include: determination of outcomes and performance quality measures; implementation of quality measures; collection of data; reviewing and analyzing data; developing and reviewing evidence based benchmarks and targets based on baseline data; identification and recognition of providers showing improvements; identification of areas needing improvement and development of corrective action plans; evaluation; and the enforcement of service and quality standards. The Quality Management Coordinator along with the Quality Management Committee evaluates the Quality Management Plan goals and objectives, and documents successes, or challenges, to the plan. The evaluation includes a reporting component available to all stakeholders and results in revisions to the plan with new goals, strategies, and indicators for the new fiscal year.

a) Clinical Quality Management

Contractual Monitoring Site Visits

The Part A Grantee Office executes and manages all contracts with funded agencies, conducts program and fiscal monitoring of service contracts, maintains a service utilization database, and participates in evaluation studies conducted by the Planning Council. The Part A Grantee Office: a) requires, by contract, that all service providers submit monthly programmatic and financial data reports; b) conducts annual program and fiscal monitoring visits to all funded agencies; and c) reports information to the Planning Council through its various Committee's and Council processes. The Part A Grantee Office performs Contractual Monitoring Site Visits which consist of a review by medical consultants to assess the scope of services and Plans of Care (POC) of the consumer for purposes of accountability requirements. The medical monitoring visit team will also conduct a review of randomly selected set of charts of minority HIV/AIDS clients for

evidence of documentation of specific data and contraction outcomes measures. Cumulative findings will be reported to the Quality Management Committee annually.

Performance Indicators and Outcomes
The Part A Grantee Office and the Planning Council assesses client-and system-level outcome tracking benchmarks throughout the EMA. The EMA processes the outcomes of implementing the CAREWare Data System and requires all Part A -funded agencies to enter information such as viral load and CD^4 counts, among other important biological and clinical indicators. The client-level data is extracted into the software module to assist with the un-duplication of client and will allow data base queries by client, provider, and service category.

Outcomes have been developed to measure the impact for each of the service categories as part of the Standards of Care (SOC). This EMA is developing and revising SOC and outcomes measures for all funded service categories.

b) Program Evaluation/Assessment

Central to the success of the QM Program are four components:

1. **Review of Quarterly Submissions:** The Part A Grantee Office periodically reviews and makes recommendations regarding the agency's data collection and analysis systems. The Part A Grantee Office will maintain a list of reports to provide feedback to the various components of the agency; this list addresses the frequency of reports and intended audience for distribution of the reports.

2. **System of Data Collection & Analysis**

    a. **Database to coordinate client care:** The West Palm Beach EMA improved the EMA- wide database for client care coordination by the implementation of the CAREWare Data System. Information extracted from the database is analyzed and used for performance measures.

3. **A Mechanism for Feedback and Evalaution**

    a. **Contractual Monitoring Site Visits:** The Part A Grantee Office developed and executed performance based contracts addressing the needs of the minority community. The Part A Grantee Office performs periodic Contractual Monitoring Site Visits of the program which consist of an evaluation of general organizational policies & procedures, quality management efforts, financial policies and procedures/financial expenditures, and other contractual requirements including the scope of services plan for purposes of accountability requirements. The method used by the granntee collects minority HIV/AIDS clients files at random to ensure that quality program measures are being met and randomly selected set of minority client charts of documentation only of specific data based on HRSA, Ryan White/PHS contractual guidelines.

b. **Coordination of Standards of Care (SOC) Assessments:** In addition to the Contractual Monitoring Site Visits, the Part A Grantee Office coordinates SOC Assessments. The SOC are designed to guide service provision and set minimum expectations in the respective service categories and serve as the basis for indicators and performance measures. These assessments focus on the adherence and implementation of the SOC specific to the various services categories currently funded under the Ryan White Part A Program. The Planning Council Committees created the SOC with the aim/approach of developing comprehensive standards that incorporated the full range of operational and clinical factors. A joint effort by the Planning Council support staff, the Quality Management Committee, and the Quality Management Coordinator is working to ensure that this ongoing approach will result in the SOC with defined and measurable outcomes that align with our Continuum of Care.

Based on HRSA priorities identified in the FY 05 – 06 Application Guidance, historical funding levels, Priority and Allocation, the Planning Council and the Part A Grantee Office have selected the following service category Standards of Care to develop in FY 07 -08:

1. Medical Case Management
2. Oral Health Services
3. Mental Health Services
4. Substance Abuse Services
5. Pharmacy Reimbursement Services
6. Transportation Services
7. Outreach Services
8. Emergency Financial Assistance

° Additionally, the Quality Management Committee, will review, evaluate and revise (as necessary) individual service categories each calendar year.

1. Review Social Standards of Care
2. Review Medical Standards of Care
3. Review Universal Standards

The following guidelines are to be utilized in updating the SOC:

- Planning Council and Part A Grantee Office jointly select 2-4 service categories to update annually. Any categories identified as high risk, as generating consumer complaints, and as being of interest to the Planning Council due to recent changes in funding levels will be selected.
- The Quality Management Committee develops a uniform format for the Standards.
- The SOC in the selected categories are sequentially reviewed, formatted, and circulated to providers for comments.

- Stakeholder input is finalized and ideas for outcomes to be measured are gathered
- Approved standards and outcomes will be measured through pilot testing SOC.

c. **Client Satisfaction Survey:** The Quality Management Coordinator has developed an EMA wide Client Satisfaction Survey Tool for all funded service categories for FY 2008.

4. **Technical Assistance Workshops:** The Part A Grantee Office coordinates yearly workshops that enhance the quality management efforts across the EMA. The impact of the technical assistance workshops facilitate to improve HIV/AIDS consumer and client outcomes by increasing the core competencies of clinics and providers.

5. GRANTEE ADMINISTRATION

a) Program Administration

The Palm Beach County Board of County Commissioners is the local governmental agency that is responsible for the administration of the Part A funds. The Board of County Commissioners designates the authority of the Part A funds to the County Administrator. An organizational chart illustrating the location of the County Administration and the Department of Community Services, who is the Grantee of the Part A, as well as the MAI Initiative Funds, is located in **Attachment 8.**

The Ryan White Part A Program Manager is responsible for the day-to-day operations of the grant, which includes distribution of grant funds based on the Request for Proposal (RFP) open competitive process. The Program Manger also supervises two Program Monitors that conduct on-site visits to service providers as well as writing contracts and preparing reports. The Financial Analyst conducts fiscal monitoring of all providers and produces all fiscal related reports for the Program Manager and Planning Council. The Fiscal Specialist is responsible for all program reimbursements. The Computer Specialist provides MIS support to the providers, technical assistance and training of any new MIS programs. The Quality Manager is responsible for the quality management program, quality plan, quality assurance committee and ensuring providers provide performance outcome measurements. At this time there are no vacancies in the Part A Program. Planning Council Support is subcontracted to the Treasure Coast Health Council.

b) Grantee Accountability

Fiscal and Program Monitoring

The ten (10) providers of Ryan White Part A services submit monthly WICY reports, reimbursements and any other required special reports.

The EMA has conducted two (2) site visits, both programmatic and fiscal monitoring for 100 percent of the ten (10) Ryan White Part A service providers. The ten (10) providers have multiple services in their contracts except for two providers. Both fiscal and programmatic monitoring were completed at the end of FY 2006/07.

In both fiscal and programmatic monitoring for FY 2006/07, 100% of the Ryan White Part A service providers were in compliance with all contract requirements with the exception of one (1) provider that had to address eligibility documentation. This requirement was corrected.

The EMA's process for corrective action once a fiscal-related or programmatic concern is identified as follows:

1. Findings are documented in a formal letter and presented to the Executive Director of the service provider agency.
2. The agency is given 30 days to correct the correct.
3. The Grantee offers technical assistance, if needed to the service provider during the 30-day time period.
4. After the corrections have been made (whether fiscal or programmatic) another site visit is arranged to verify the corrections.
5. If corrective action has not been satisfied further steps will be taken, including freezing reimbursements or termination of contract.

The redistribution of funds is done quarterly. If a service provider is under spending, then the Grantee redistributes to services, usually in the medical category, with a higher priority set by the Priorities & Allocations committee. Contract amendments are completed in a timely manner to redistribute funds after an agenda item is submitted to the Board of County Commissioners.

c) Third Party Reimbursement

The WPB EMA makes every effort to ensure that the CARE Act is the payer of last resort. This process includes a common eligibility process where all clients are thoroughly screened for any other payer source for medical services. The screening consists of a financial assessment, which includes a Medicaid or in this EMA' s case Health Care District (Palm Beach County Taxing District) denial letter that is attached to the client's records. In addition, on all Primary Medical enrollment forms and Specialty Medical referral forms, a case manager must certify with a signature from their supervisor that the screening was conducted and that Ryan White CARE Act funds are being used as "Payer of Last Resort". Services will not be approved unless this certification is made and appropriate documentation on eligibility is available

Ensuring that Care Act funds are used as the payer of last resort is a contract requirement between the Grantee and the subcontractors. The contract requires that the subcontractor maintain client records, containing evidence of financial benefit and entitlement eligibility, including documentation of **NO** other payer source, indicating their qualification for Ryan White Part A services. During the program and fiscal monitoring this documentation is verified for compliance and is documented in the subcontractors file with the Grantee, as per contractual agreement. If it found that a client is eligible for another source of funding and the funding will be reimbursed to the Grantee.

The **State Medicaid** program has a positive impact covering PLWH health care costs in this EMA. The screening process and financial assessment of each client insures that these clients are eligible for Medicaid, which in turn reduces cost for the Ryan White Part A program. In some instances, Ryan White Part A covers cost and services that are not part of the State Medicaid program benefits. These services would be Dental Assistance, Nurse Care

Coordination and other ancillary services that Ryan White Part A provides and State Medicaid does not.

State Medicaid implemented a program call Disease Management Organization (DMO), which has increased enrollment through identification of Medicaid recipients that have received services that might suggest eligibility for Project AIDS Care Waiver Program (PAC), which also reduces costs to the Ryan White Part A program.

6. BUDGET

The Budget (Form SF 424A) is located in **Attachment 2**, as part of the required Application Form 5161-1.

Budget Totals 07/08

Administrative		$100,000
Quality Management	$50,000	
HIV Services		$1,000,000
Contractual		
Medical Case Management	$500,000	
Drug Reimbursement Program	$200,000	
Oral Health Care	$100,000	
Food Bank/Home Delivery meals	$100.000	
Medical Transportation	$100,000	
Total Budget		$1,150,000

The Budget Justification is located in **Attachment 2**, which includes detailed budgetary information for FY 07/08, FY08/09 and FY 09/10.

Appendix C: Agreements and Compliance Assurances for the FY 2007 Part A Minority AIDS Initiative Grant

The Chief Elected Official (CEO) of all Part A-Emergency Relief for Areas with Substantial Need for Services (Part A), or her/his designee, must include a signed copy of the attached assurances with the Part F, Subpart III-Minority AIDS Initiative (MAI) application, that must be satisfied in order to qualify for a MAI grant award as required under Title XXVI of the Public Health Service Act as amended by the RYAN WHITE HIV/AIDS TREATMENT MODERNIZATION ACT OF 2006.

RYAN WHITE HIV/AIDS TREATMENT MODERNIZATION ACT OF 2006 FY 2007 Part A MAI Agreements and Compliance Assurances

I, the Chief Elected Official for the *Part A-Emergency Relief for Areas with Substantial Need for Services* (hereinafter referred to as *Part A*) grant in West Palm Beach, Palm Beach County as designated pursuant to Title XXVI of the Public Health Service (PHS) Act as amended by the Ryan White HIV/AIDS Treatment Modernization Act of 2006, do hereby certify that:

A. Pursuant to Section 2693(b)(2)(A) of the PHS Act, MAI funds will be used for the purpose of improving "*...HIV-related health outcomes to reduce existing racial and ethic health disparities;* and

B. MAI funds and services will be allocated and administered in accordance with the *FY 2007 Part A Ryan White Program Agreements and Compliance Assurances* submitted to the Health Resources and Services Administration.

SIGNED: Addie L. Greene **(Chief Elected Official)**

Title: Chairperson, Palm Beach County Board of County Commissioners

Date signed: 5/23/07

APPROVED AS TO FORM AND LEGAL SUFFICIENCY

COUNTY ATTORNEY

Attachment 2: Table of Contents

SF424 Budget Information

FY 07/08 Budget Narrative/Justification 1

FY 08/09 Budget Narrative/Justification 2

FY 09/10 Budget Narrative/Justification 3

OMB Approval No. 0348-0044

BUDGET INFORMATION - Non-Construction Programs

SECTION A - BUDGET SUMMARY						
Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. MAI Grant Program	93.914	$	$	$ 1,150,000.00	$	$ 1,150,000.00
2.						0.00
3.						0.00
4.						0.00
5. TOTALS		$ 0.00	$ 0.00	$ 1,150,000.00	$ 0.00	$ 1,150,000.00

SECTION B - BUDGET CATEGORIES					
6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY				Total (5)
	(1)	(2)	(3)	(4)	
a. Personnel	$	$	$	$	$ 0.00
b. Fringe Benefits					0.00
c. Travel					0.00
d. Equipment					0.00
e. Supplies					0.00
f. Contractual	100,000.00	50,000.00	1,000,000.00		1,150,000.00
g. Construction					0.00
h. Other					0.00
i. Total Direct Charges *(sum of 6a - 6h)*	100,000.00	50,000.00	1,000,000.00	0.00	1,150,000.00
j. Indirect Charges					0.00
k. TOTALS *(sum of 6i and 6j)*	$ 100,000.00	$ 50,000.00	$ 1,000,000.00	$ 0.00	$ 1,150,000.00
7. Program Income	$	$	$	$	$ 0.00

SECTION C - NON-FEDERAL RESOURCES

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e) TOTALS
8.	$	$	$	$ 0.00
9.				0.00
10.				0.00
11.				0.00
12. TOTALS *(sum of lines 8 and 11)*	$ 0.00	$ 0.00	$ 0.00	$ 0.00

SECTION D - FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	$ 0.00	$	$	$	$
14. Non-Federal	0.00				
15. TOTAL *(sum of lines 13 and 14)*	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT

(a) Grant Program	FUTURE FUNDING PERIODS (Years)			
	(b) First	(c) Second	(d) Third	(e) Fourth
16. MAI Grant Program	$ 1,150,000.00	$ 1,150,000.00	$ 1,150,000.00	$
17.				
18.				
19.	$	$	$	$
20. TOTALS *(sum of lines 16 - 19)*	$1,150,000.00	$1,150,000.00	$1,150,000.00	$0.00

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges:	22. Indirect Charges:

23. Remarks

Part A - Ryan White Program, MAI

Budget Narrative/Justification

August 01, 2007 to July 31, 2008

	Detail Cost	Total Cost
ADMINISTRATIVE		$ 100,000
CONTRACTUAL		
Contract with consultant to develop MAI indicators for the new priority areas and the monitoring of those indicators. Complete a study and comprehensive assessment on improving access to services, behavioral changes and retention in care. Work to improve minority community involvement.	$ 65,000	
Contract with consultant for the development of a database that will allow the Grantee to have a complete picture of the MAI usage. This data will support all aspects of MAI continuim of care	$ 35,000	
QUALITY MANAGEMENT		$ 50,000
Contract with consultant to track, assess and evaluate MAI indicators for the new priority areas.	$ 50,000	
HIV SERVICES		$ 1,000,000
CONTRACTUAL		
Medical Case Management Includes: Arranging of client-centered services that links clients with Primary Medical Care, Psychosocial and other services to insure timely, coordinated access to medically-appropriate levels of health and support services and continuity of care. Initial assessment of eligibility for Ryan White funded services. Provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments.	$ 500,000	
Drug Reimbursement Program AIDS Pharmaceutical Assistance Includes: Local pharmacy assistance programs to provide HIV/AIDS medications to clients. Program will expand the number of covered medications available to ADAP eligible patients to prolong life or prevent the serious deterioration of health, and to reimburse Ryan White eligible patients with private insurance for prescription co-pays. Vaccines, intra muscular injections and intravenous injections to be delivered in a primary care setting. Pharmacy pickup services available on a County wide basis, coordinated to track adherence and compliance.	$ 200,000	
Oral Health Care Includes: Diagnostic, preventive, and theraputive services provided by specialty trained dental care providers. Will provide routine dental care examinations and prophylaxis, X-rays, treatment of gum diseases, oral surgery, and medically necessary dentures.	$ 100,000	

	Detail Cost	Total Cost
Food Bank/Home Delivered Meals		
Food Bank/Home Delivered Meals Provision of actual food or meals to enhance the daily nutritional health of Ryan White eligible clients and their families. Availability of food vouchers for culturally diverse populations. Home delivered meals for those unable to visit pantry sites.	$ 100,000	
Medical Transportation		
Transportation Conveyance services provided to a client in order to access health care or psycho-social support services. May be provided routinely or on an emergency basis. Transportation services must be appropriate to the client's level of disability and priority shall be given to transportation services that link the client with health care services.	$ 100,000	
TOTAL BUDGET		$ 1,150,000

August 01, 2008 to July 31, 2009

	Detail Cost	Total Cost
ADMINISTRATIVE		$ 100,000
CONTRACTUAL		
Contract with consultant to develop MAI indicators for the new priority areas and the monitoring of those indicators. Complete a study and comprehensive assessment on improving access to services, behavioral changes and retention in care. Work to improve minority community involvement.	$ 65,000	
Contract with consultant for the development of a database that will allow the Grantee to have a complete picture of the MAI usage. This data will support all aspects of MAI continuim of care	$ 35,000	
QUALITY MANAGEMENT		$ 50,000
Contract with consultant to track, assess and evaluate MAI indicators for the new priority areas.	$ 50,000	
HIV SERVICES		$ 1,000,000
CONTRACTUAL		
Medical Case Management Includes: Arranging of client-centered services that links clients with Primary Medical Care, Psychosocial and other services to insure timely, coordinated access to medically-appropriate levels of health and support services and continuity of care. Initial assessment of eligibility for Ryan White funded services. Provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments.	$ 500,000	

	Detail Cost	Total Cost
Drug Reimbursement Program		
AIDS Pharmaceutical Assistance Includes: Local pharmacy assistance programs to provide HIV/AIDS medications to clients. Program will expand the number of covered medications available to ADAP eligible patients to prolong life or prevent the serious deterioration of health, and to reimburse Ryan White eligible patients with private insurance for prescription co-pays. Vaccines, intra muscular injections and intravenous injections to be delivered in a primary care setting. Pharmacy pickup services available on a County wide basis, coordinated to track adherence and compliance.	$ 200,000	
Oral Health Care Includes: Diagnostic, preventive, and theraputive services provided by specialty trained dental care providers. Will provide routine dental care examinations and prophylaxis, X-rays, treatment of gum diseases, oral surgery, and medically necessary dentures.	$ 100,000	
Food Bank/Home Delivered Meals		
Food Bank/Home Delivered Meals Provision of actual food or meals to enhance the daily nutritional health of Ryan White eligible clients and their families. Availability of food vouchers for culturally diverse populations. Home delivered meals for those unable to visit pantry sites.	$ 100,000	
Medical Transportation		
Transportation Conveyance services provided to a client in order to access health care or psycho-social support services. May be provided routinely or on an emergency basis. Transportation services must be appropriate to the client's level of disability and priority shall be given to transportation services that link the client with health care services.	$ 100,000	
TOTAL BUDGET		$ 1,150,000

August 01, 2009 to July 31, 2010

	Detail Cost	Total Cost
ADMINISTRATIVE		$ 100,000
CONTRACTUAL		
Contract with consultant to develop MAI indicators for the new priority areas and the monitoring of those indicators. Complete a study and comprehensive assessment on improving access to services, behavioral changes and retention in care. Work to improve minority community involvement.	$ 65,000	
Grant Application Consultant Contracts for assistance in the preparation of the grant application	$ 35,000	

Part A - Ryan White Program, MAI

	Detail Cost	Total Cost
QUALITY MANAGEMENT		$ 50,000
Contract with consultant to track, assess and evaluate MAI indicators for the new priority areas.	$ 50,000	
HIV SERVICES		$ 1,000,000
CONTRACTUAL		
Medical Case Management	$ 500,000	
Includes: Arranging of client-centered services that links clients with Primary Medical Care, Psychosocial and other services to insure timely, coordinated access to medically-appropriate levels of health and support services and continuity of care. Initial assessment of eligibility for Ryan White funded services. Provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments.		
Drug Reimbursement Program		
AIDS Pharmaceutical Assistance	$ 200,000	
Includes: Local pharmacy assistance programs to provide HIV/AIDS medications to clients. Program will expand the number of covered medications available to ADAP eligible patients to prolong life or prevent the serious deterioration of health, and to reimburse Ryan White eligible patients with private insurance for prescription co-pays. Vaccines, intra muscular injections and intravenous injections to be delivered in a primary care setting. Pharmacy pickup services available on a County wide basis, coordinated to track adherence and compliance.		
Oral Health Care	$ 100,000	
Includes: Diagnostic, preventive, and theraputive services provided by specialty trained dental care providers. Will provide routine dental care examinations and prophylaxis, X-rays, treatment of gum diseases, oral surgery, and medically necessary dentures.		
Food Bank/Home Delivered Meals		
Food Bank/Home Delivered Meals	$ 100,000	
Provision of actual food or meals to enhance the daily nutritional health of Ryan White eligible clients and their families. Availability of food vouchers for culturally diverse populations. Home delivered meals for those unable to visit pantry sites.		
Medical Transportation		
Transportation	$ 100,000	
Conveyance services provided to a client in order to access health care or psycho-social support services. May be provided routinely or on an emergency basis. Transportation services must be appropriate to the client's level of disability and priority shall be given to transportation services that link the client with health care services.		
TOTAL BUDGET		$ 1,150,000

Attachment 3: HIV/AIDS Incidence and Prevalence Epidemiological Tables

HIV and AIDS Incidence, HIV/AIDS Deaths 1

Demographic Group/Exposure Category 2

Demographic Group/Exposure Category (Risks Redistributed) 4

"Section 2617 (B)(2) states that the application for Title II funds shall contain a determination of the size and demographics of the population of people living with HIV in the State." [CARE Act]

HIV and AIDS Incidence, HIV/AIDS Deaths (excl DOC).

Demographic Group/ Exposure Category	AIDS Incidence in 2004 & 2005 — AIDS Incidence is defined as the number of new AIDS cases diagnosed during the period specified, data as of 01/06/06					HIV Cases (regardless of current AIDS Status) Reported in 2004 & 2005 — HIV Cases (regardless of current AIDS Status) Reported: is defined as the number of new HIV cases reported during the period specified, data as of 01/06/06					HIV/AIDS Case Deaths in 2004 & 2005 — HIV or AIDS cases that died (regardless of cause) in 2005, data as of 04/05/06				
Race/Ethnicity	2004	% of Total	2005	% of Total	% change	2004	% of Total	2005	% of Total	% change	2004	% of Total	2005	% of Total	% change
White, not Hispanic	103	24%	67	19%	-35.0%	126	28%	99	25%	-21.4%	49	20%	52	25%	6.1%
Black, not Hispanic	264	61%	224	62%	-15.2%	248	54%	238	60%	-4.0%	157	64%	138	65%	-12.1%
Hispanic	64	15%	64	18%	0.0%	72	16%	59	15%	-18.1%	36	15%	17	8%	-52.8%
Asian/Pacific Islander	1	0%	1	0%	0.0%	7	2%	0	0%	-100.0%	0	0%	1	0%	#DIV/0!
American Indian/Alaskan Native	0	0%	0	0%	#DIV/0!	0	0%	0	0%	#DIV/0!	0	0%	1	0%	#DIV/0!
Not Specified/Other	4	1%	4	1%	0.0%	4	1%	1	0%	-75.0%	2	1%	3	1%	50.0%
Total:	436	100%	360	100%	-17.4%	457	100%	397	100%	-13.1%	244	100%	212	100%	-13.1%
Gender	2004	% of Total	2005	% of Total	% change	2004	% of Total	2005	% of Total	% change	2004	% of Total	2005	% of Total	% change
Male	283	64.9%	215	59.7%	-24.0%	275	60.2%	226	56.9%	-17.8%	162	66.4%	123	58.0%	-24.1%
Female	153	35.1%	145	40.3%	-5.2%	182	39.8%	171	43.1%	-6.0%	82	33.6%	89	42.0%	8.5%
Total:	436	100.0%	360	100.0%	-17.4%	457	100.0%	397	100.0%	-13.1%	244	100.0%	212	100.0%	-13.1%
Age at Diagnosis (Years)	2004	% of Total	2005	% of Total	% change	2004	% of Total	2005	% of Total	% change	2004	% of Total	2005	% of Total	% change
0- 2 years	0	0.0%	0	0.0%	#DIV/0!	0	0.0%	3	0.8%	#DIV/0!	2	0.8%	0	0.0%	-100.0%
3-12 years	2	0.5%	1	0.3%	-50.0%	1	0.2%	3	0.8%	200.0%	0	0.0%	0	0.0%	#DIV/0!
13-19 years	4	0.9%	4	1.1%	0.0%	14	3.1%	10	2.5%	-28.6%	3	1.2%	6	2.8%	100.0%
20-24 years	15	3.4%	13	3.6%	-13.3%	26	5.7%	34	8.6%	30.8%	15	6.1%	10	4.7%	-33.3%
25-29 years	29	6.7%	27	7.5%	-6.9%	46	10.1%	44	11.1%	-4.3%	22	9.0%	23	10.8%	4.5%
30-39 years	134	30.7%	119	33.1%	-11.2%	143	31.3%	110	27.7%	-23.1%	86	35.2%	63	29.7%	-26.7%
40-44 years	83	19.0%	71	19.7%	-14.5%	86	18.8%	67	16.9%	-22.1%	35	14.3%	39	18.4%	11.4%
45-49 years	73	16.7%	50	13.9%	-31.5%	64	14.0%	44	11.1%	-31.3%	21	8.6%	24	11.3%	14.3%
50-59 years	72	16.5%	58	16.1%	-19.4%	58	12.7%	63	15.9%	8.6%	38	15.6%	33	15.6%	-13.2%
60+ years	24	5.5%	17	4.7%	-29.2%	19	4.2%	19	4.8%	0.0%	22	9.0%	14	6.6%	-36.4%
Total:	436	100.0%	360	100.0%	-17.4%	457	100.0%	397	100.0%	-13.1%	244	100.0%	212	100.0%	-13.1%

HIV data (for 2005) includes those cases that have converted to AIDS. These HIV cases cannot be added with AIDS cases to get combined totals since the categories are not mutually

Demographic Group/ Exposure Category	AIDS Incidence in 2004 & 2005 AIDS Incidence is defined as the number of new AIDS cases diagnosed during the period specified, data as of 01/06/06.					HIV Cases (regardless of current AIDS Status) Reported in 2004 & 2005 HIV Cases (regardless of current AIDS Status) Reported: Is defined as the number of new HIV cases reported during the period specified, data as of 01/06/06.					HIV/AIDS Case Deaths in 2004 & 2005 HIV or AIDS cases that died (regardless of cause) in 2005, data as of 04/05/06.				
Male Adult Exposure Category Risks Redistributed	2004	% of Total	2005	% of Total	% change	2004	% of Total	2005	% of Total	% change	2004	% of Total	2005	% of Total	% change
MSM	120	42.8%	129	60.3%	7.2%	156	57.1%	140	62.5%	-10.4%	73	45.5%	46	37.1%	-37.6%
IDU	21	7.6%	13	6.2%	-37.6%	13	4.8%	9	4.1%	-30.1%	16	10.1%	8	6.4%	-51.9%
MSM/IDU	8	2.8%	3	1.4%	-61.5%	7	2.6%	2	0.9%	-71.4%	4	2.5%	11	9.3%	185.9%
Heterosexual	131	46.5%	68	31.6%	-48.2%	98	35.6%	73	32.5%	-25.4%	67	41.3%	57	46.4%	-14.2%
Other	1	0.4%	1	0.5%	0.0%	0	0.0%	0	0.0%	#DIV/0!	1	0.6%	1	0.8%	0.0%
Total:	281	100.0%	214	100.0%	-23.8%	274	100.0%	224	100.0%	-18.2%	161	100.0%	123	100.0%	-23.6%
Female Adult Exposure Category Risks Redistributed	2004	% of Total	2005	% of Total	% change	2004	% of Total	2005	% of Total	% change	2004	% of Total	2005	% of Total	% change
IDU	14	9.0%	10	7.0%	-25.9%	12	6.5%	25	15.0%	110.0%	17	20.9%	18	20.4%	7.5%
Heterosexual	135	88.5%	135	93.0%	-0.4%	170	93.5%	142	85.0%	-16.5%	64	79.1%	71	79.6%	10.5%
Other	4	2.5%	0	0.0%	-100.0%	0	0.0%	0	0.0%	#DIV/0!	0	0.0%	0	0.0%	#DIV/0!
Total:	153	100.0%	145	100.0%	-5.2%	182	100.0%	167	100.0%	-8.2%	81	100.0%	89	100.0%	9.9%
Pediatric AIDS Exposure Categories (ages 0-12)	2004	% of Total	2005	% of Total	% change	2004	% of Total	2005	% of Total	% change	2004	% of Total	2005	% of Total	% change
Mother with/at risk for HIV infection	2	100%	1	100%	-50.0%	1	100%	6	100%	500.0%	2	100%	0	#DIV/0!	-100.0%
Risk not reported/Other	0	0%	0	0%	#DIV/0!	0	0%	0	0%	#DIV/0!	0	0%	0	#DIV/0!	#DIV/0!
Total:	2	100%	1	100%	-50.0%	1	100%	6	100%	500.0%	2	100%	0	#DIV/0!	-100.0%

HIV data (for 2005) includes those cases that have converted to AIDS. These HIV cases cannot be added with AIDS cases to get combined totals since the categories are not mutually

Demographic Group/ Exposure Category	AIDS Incidence in 2004 & 2005					HIV Cases (regardless of current AIDS Status) Reported in 2004 & 2005					HIV/AIDS Case Deaths in 2004 & 2005				
	AIDS Incidence is defined as the number of new AIDS cases diagnosed during the period specified; data as of 01/06/06.					HIV Cases (regardless of current AIDS Status) Reported: is defined as the number of new HIV cases reported during the period specified; data as of 01/06/06.					HIV or AIDS cases that died (regardless of cause) in 2005; data as of 04/05/06.				
Special Populations Risks NOT Redistributed	2004	% of Total	2005	% of Total	% change	2004	% of Total	2005	% of Total	% change	2004	% of Total	2005	% of Total	% change
White MSM*	59	N/A	37	N/A	-37.3%	84	N/A	50	N/A	-40.5%	31	N/A	28	N/A	-9.7%
Black MSM*	31	N/A	46	N/A	48.4%	32	N/A	44	N/A	37.5%	29	N/A	13	N/A	-55.2%
Hispanic MSM*	19	N/A	25	N/A	31.6%	27	N/A	20	N/A	-25.9%	10	N/A	7	N/A	-30.0%
Whte Male IDU**	6	N/A	0	N/A	-100.0%	7	N/A	2	N/A	-71.4%	6	N/A	7	N/A	16.7%
Black Male IDU**	9	N/A	7	N/A	-22.2%	6	N/A	5	N/A	-16.7%	10	N/A	8	N/A	-20.0%
Hispanic Male IDU**	3	N/A	6	N/A	100.0%	4	N/A	1	N/A	-75.0%	2	N/A	1	N/A	-50.0%
Whte Female IDU**	3	N/A	3	N/A	0.0%	3	N/A	11	N/A	266.7%	4	N/A	6	N/A	50.0%
Black Female IDU**	5	N/A	2	N/A	-60.0%	2	N/A	4	N/A	100.0%	10	N/A	7	N/A	-30.0%
Hispanic Female IDU**	3	N/A	3	N/A	0.0%	4	N/A	2	N/A	-50.0%	0	N/A	0	N/A	#DIV/0!
Whte Male Homeless	0	N/A	0	N/A	#DIV/0!	0	N/A	0	N/A	#DIV/0!	0	N/A	0	N/A	#DIV/0!
Black Male Homeless	0	N/A	0	N/A	#DIV/0!	0	N/A	0	N/A	#DIV/0!	1	N/A	2	N/A	100.0%
Hispanic Male Homeless	0	N/A	0	N/A	#DIV/0!	0	N/A	0	N/A	#DIV/0!	0	N/A	0	N/A	#DIV/0!
Whte Female Homeless	0	N/A	0	N/A	#DIV/0!	0	N/A	0	N/A	#DIV/0!	0	N/A	0	N/A	#DIV/0!
Black Female Homeless	0	N/A	0	N/A	#DIV/0!	0	N/A	0	N/A	#DIV/0!	1	N/A	0	N/A	-100.0%
Hispanic Female Homeless	0	N/A	0	N/A	#DIV/0!	0	N/A	0	N/A	#DIV/0!	0	N/A	0	N/A	#DIV/0!
Male Haitian Born	47	N/A	33	N/A	-29.8%	29	N/A	22	N/A	-24.1%	25	N/A	20	N/A	-20.0%
Female Haitian Born	30	N/A	26	N/A	-13.3%	34	N/A	37	N/A	8.8%	12	N/A	10	N/A	-16.7%
Whte Male Youth (ages 13-24)	2	N/A	0	N/A	-100.0%	2	N/A	5	N/A	150.0%	1	N/A	0	N/A	-100.0%
Black Male Youth (ages 13-24)	4	N/A	9	N/A	125.0%	11	N/A	14	N/A	27.3%	2	N/A	0	N/A	-100.0%
Hispanic Male Youth (ages 13-24)	2	N/A	0	N/A	-100.0%	5	N/A	1	N/A	-80.0%	1	N/A	2	N/A	100.0%
Whte Female Youth (ages 13-24)	0	N/A	1	N/A	#DIV/0!	4	N/A	3	N/A	-25.0%	0	N/A	2	N/A	#DIV/0!
Black Female Youth (ages 13-24)	10	N/A	6	N/A	-40.0%	12	N/A	16	N/A	33.3%	5	N/A	4	N/A	-20.0%
Hispanic Female Youth (ages 13-24)	0	N/A	0	N/A	#DIV/0!	4	N/A	5	N/A	25.0%	0	N/A	1	N/A	#DIV/0!
White WCBA* (ages 15-44)	9	N/A	12	N/A	33.3%	15	N/A	22	N/A	46.7%	7	N/A	10	N/A	42.9%
Black WCBA* (ages 15-44)	78	N/A	77	N/A	-1.3%	94	N/A	74	N/A	-21.3%	50	N/A	47	N/A	-6.0%
Hiapanic WCBA* (ages 15-44)	10	N/A	14	N/A	40.0%	18	N/A	15	N/A	-16.7%	4	N/A	5	N/A	25.0%
White Ped Cases (ages 0-12)	0	N/A	0	N/A	#DIV/0!	0	N/A	0	N/A	#DIV/0!	0	N/A	0	N/A	#DIV/0!
Black Ped Cases (ages 0-12)	2	N/A	1	N/A	-50.0%	1	N/A	5	N/A	400.0%	0	N/A	0	N/A	#DIV/0!
Hispanic Ped Cases (ages 0-12)	0	N/A	0	N/A	#DIV/0!	0	N/A	1	N/A	#DIV/0!	2	N/A	0	N/A	-100.0%
DOC cases	4	N/A	1	N/A	-75.0%	7	N/A	7	N/A	0.0%	0	N/A	0	N/A	#DIV/0!

*WCBA=Women of Child Bearing Age

HIV data (for 2005) includes those cases that have converted to AIDS. These HIV cases cannot be added with AIDS cases to get combined totals since the categories are not mutually

*MSM includes MSM & MSM/IDU

**Male IDU includes IDU & MSM/IDU

"*Section 2617 (B)(2) states that the application for Title II funds shall contain a determination of the size and demographics of the population of people living with HIV in the State.*" [CARE Act]

Table 1: AIDS INCIDENCE, AIDS PREVALENCE AND HIV (NOT AIDS) PREVALENCE

Demographic Group/ Exposure Category RISKS REDISTRIBUTED	AIDS Incidence in 2004-2005 AIDS Incidence is defined as the number of new AIDS cases diagnosed during the period specified, data as of 01/06/06.		AIDS Prevalence Estimates (excl DOC) through 2005 as of 04/05/06 AIDS Prevalence is defined as the number of reported AIDS Cases plus 5% for unreported AIDS cases.		HIV (not AIDS) Prevalence Estimate, 2005, as of 04/05/06 Adjusted for underreporting PLWH (not AIDS) and includes those diagnosed but not reported. (Total PLWAH minus AIDS Prevalence).	
Race/Ethnicity	#	% of Total	#	% of Total	#	% of Total
White, not Hispanic	170	21%	1,037	23%	1,568	24%
Black, not Hispanic	488	61%	2,943	66%	4,164	64%
Hispanic	128	16%	458	10%	657	10%
Asian/Pacific Islander	2	0%	3	0%	27	0%
American Indian/Alaskan Native	0	0%	1	0%	1	0%
Not Specified/Other	8	1%	32	1%	42	1%
Total:	796	100%	4,474	100%	6,459	100%
Gender	#	% of Total	#	% of Total	#	% of Total
Male	498	63%	2,871	64%	3,747	58%
Female	298	37%	1,603	36%	2,712	42%
Total:	796	100%	4,474	100%	6,459	100%
Age at Diagnosis (Incidence) / Current Age (Prevalence)	#	% of Total	#	% of Total	#	% of Total
0-12 years	3	0%	38	1%	34	1%
13-19 years	8	1%	60	1%	68	1%
20-44 years	491	62%	1,961	44%	3,479	54%
45+ years	294	37%	2,415	54%	2,878	45%
Total:	796	100%	4,474	100%	6,459	100%

Table 1: AIDS INCIDENCE, AIDS PREVALENCE AND HIV (NOT AIDS) PREVALENCE (CONT'D)

Demographic Group/ Exposure Category RISKS REDISTRIBUTED	AIDS Incidence in 2004-2005		AIDS Prevalence Estimates (excl DOC) through 2005 as of 04/05/06		HIV (not AIDS) Prevalence Estimate, 2005, as of 04/05/06	
	AIDS Incidence is defined as the number of new AIDS cases diagnosed during the period specified, data as of 01/06/06.		AIDS Prevalence is defined as the number of reported AIDS Cases plus 5% for unreported AIDS cases.		Adjusted for underreporting PLWH (not AIDS) and includes those diagnosed but not reported. (Total PLWAH minus AIDS Prevalence)	
Adult/Adolescent AIDS Exposure Category	#	% of Total	#	% of Total	#	% of Total
MSM	249	31%	1,258	28%	1,706	27%
IDU	59	7%	438	10%	549	9%
MSM/IDU	11	1%	118	3%	117	2%
Heterosexual	468	59%	2,534	57%	3,980	62%
Other	6	1%	87	2%	73	1%
Total:	793	100%	4,435	100%	6,424	100%
Pediatric AIDS Exposure Categories (ages 0-12)	#	% of Total	#	% of Total	#	% of Total
Mother with/at risk for HIV infection	3	100%	38	97%	34	98%
Risk not reported/Other	0	0%	1	3%	1	2%
Total:	3	100%	39	100%	35	100%

PALM BEACH EMA
Unmet Need Framework Table

Column 1	Column 2	Column 3	Column 4	Column 5
	Population Sizes	**Value**		**Data Source(s)**
Row A.	Number of persons living with AIDS (PLWA), for the period of 01/01/2005 - 12/31/05	4,474		HARS + estimates
Row B.	Number of persons living with HIV (PLWH)/non-AIDS/aware, for the period of 01/01/2005 - 12/31/05	4,274		HARS + estimates
Row C.	Total number of HIV+aware, for the period of 01/01/2005 - 12/31/05	8,748		
	Care Patterns	**Value**		**Data Source(s)**
Row D.	Number of PLWA who received the specified HIV primary medical care services in 12-month period	2,966		HARS plus matches with ADAP and Medicaid
Row E.	Number of PLWH/non-AIDS/aware who received the specified HIV primary medical care services in 12-month period	2,041		HARS plus matches with ADAP and Medicaid
Row F.	Total number of HIV+/aware who received the specified HIV primary medical care services in 12-month period	5,008		
	Calculated Results	**Value**	**Percent**	**Calculation**
Row G.	Number of PLWA who did not receive primary medical services	1,507	34%	Value: Value A - Value D. Percent: Value G/Value A.
Row H.	Number of PLWH/non-AIDS/aware who did not receive primary medical services	2,233	52%	Value: Value B - Value E. Percent: Value H/Value B.
Row I.	Total HIV+/aware not receiving specified primary medical care services (quantified estimate of unmet need)	3,740	43%	Value: Value G + Value H. Percent: Value I/Value C

FY07 Planned Part A & MAI Allocations Table for Use with the Part A Minority AIDS Initiative Grant Application

Name of Grantee: WEST PALM BEACH

	Service Category	1. Part A Grant Service Dollars		2. MAI Grant Service Dollars	
		1a. Amount	1b.Percent	2a. Amount	2b. Percent
	Core Medical Services				
a.	Outpatient /Ambulatory health services	$1,733,002	35.34%		0.00%
b.	AIDS Drug Assistance Program (ADAP) treatments	$200,000	4.08%		0.00%
c.	AIDS Pharmaceutical Assistance (local)	$438,573	8.94%	$200,000	20.00%
d.	Oral health care	$248,176	5.06%	$100,000	10.00%
e.	Early Intervention Services		0.00%		0.00%
f.	Health Insurance Premium & Cost Sharing Assistance	$34,856	0.71%		0.00%
g.	Home health care	$139,425	2.84%		0.00%
h.	Home and Community-based Health Services		0.00%		0.00%
i.	Hospice Services		0.00%		0.00%
j.	Mental health services	$212,588	4.33%		0.00%
k.	Medical Nutrition Therapy	$17,428	0.36%		0.00%
l.	Medical Case Management (including Treatment Adherence)	$1,304,912	26.61%	$500,000	50.00%
m.	Substance abuse services–outpatient	$30,325	0.62%		0.00%
	Support Services				
n.	Case Management (non-Medical)		0.00%		0.00%
o.	Child care services		0.00%		0.00%
p.	Emergency financial assistance	$52,474	1.07%		0.00%
q.	Food bank/home-delivered meals	$52,473	1.07%	$100,000	10.00%
r.	Health education/risk reduction		0.00%		0.00%
s.	Housing services	$126,408	2.58%		0.00%
t.	Legal services	$139,274	2.84%		0.00%
u.	Linguistics Services		0.00%		0.00%
v.	Medical Transportation Services	$34,818	0.71%	$100,000	10.00%
w.	Outreach services	$139,274	2.84%		0.00%
x.	Psychosocial support services		0.00%		0.00%
y.	Referral for health care/supportive services		0.00%		0.00%
z.	Rehabilitation services		0.00%		0.00%
aa.	Respite care		0.00%		0.00%
ab.	Treatment adherence counseling		0.00%		0.00%
	Total Service Dollar Allocations	$4,904,006	100.00%	$1,000,000	100.00%

Non-Service Allocations	3.Part A Grant Non-Service Dollars		4.MAI Grant Non-Service Dollars	
	3a. Amount	Percent	4a.Amount	4b.Percent
Clinical Quality Management	$288,471	5.00%	$50,000	5.00%
Grantee Administration	$584,961	10.00%	$100,000	10.00%
Total Non-service Allocations		0.00%		0.00%

Do NOT enter data for **Total Planned Grant Funds**, as these cells will be automatically summed.

Total FY 2007 Grant Funds	$4,904,006	100.00%	$1,000,000	100.00%

Attachment 6: FY 2007 Implementation Plan

Service Priority: Medical Case Management 1

Service Priority: Dental (Oral Health Care) 2

Service Priority: Transportation 3

FY 2007 MAI Implementation Plan
GRANTEE: West Palm Beach EMA

Service Priority Name: Medical Case Management	**Total Priority Allocation: $500,000**
Service Goal: To provide a range of Primary Medical Care to Haitians & Afro-Americans	

Objective/s: The objectives listed will apply to each community during the FY07 project period. To provide and expand Medical Case Management to Haitian and Afro-Americans that provide culturally appropriate services. To improve health care and adherence to treatment.

Community(s) to be Served *List all racial/ethnic minority communities to receive this service*	**Service Unit Definition:** Define *the unit of service to be provided*	**Quantity**		**Time Frame:** *Indicate the estimated duration of activity relating to the objective listed*	**FY 2007 Funds:** *Provide the approximate amount of MAI funds to be used to provide this service.*
		Number of People to be Served	**Total number of Service Units to be Provided**		
a. Haitians	15 min. encounter = 1 unit of service	300	28,846	8/1/07-7/31/08	$375,000
b. Afro-Americans	15 min. encounter =1 unit of service	100	9,615	8/1/07-7/31/08	$125,000

Planned Client-Level Health Outcome(s) and Indicators:
#1. Outcome: Increase enrollment/adherence for those individuals that are not currently receiving primary medical care. Indicators: Target: 75% not in care will receive medical care.
#2. Outcome: Increase CD4 count and decrease viral load levels for clients receiving and maintaining care under this initiative. Indicators: 75% of clients served with improved CD4 counts.
#3. Outcome: Increase improved health care and decrease hospitalizations for target populations. Indicators: 75% of patients will have improved health care and a decrease in hospital stays.

Service Priority Name: Drug Reimbursement	**Total Priority Allocation: $200,000**
Service Goal: To increase access to HIV related medications to PLWHA's in Haitian & Afro-Am. communities in WPB EMA that have no other funding source.	

Objective/s: To expand local/ADAP FDA approved medications/formulary for Haitians and Afro-Americans unable to pay for such medications during FY07.

Community(s) to be Served *List all racial/ethnic minority communities to receive this service*	**Service Unit Definition:** Define *the unit of service to be provided*	Quantity		**Time Frame:** *Indicate the estimated duration of activity relating to the objective listed*	**FY 2007 Funds:** *Provide the approximate amount of MAI funds to be used to provide this service.*
		Number of People to be Served	**Total number of Service Units to be Provided**		
a. Haitians	1 month filled prescription	347	7,905	8/1/07-7/31/08	$150,000
b. Afro-Americans	1 month filled prescription	115	2,621	8/1/07-7/31/08	$50,000

Planned Client-Level Health Outcome(s) and Indicators:
#1. Outcome: Increase adherence for those individuals that are not currently receiving HIV related approved medications. Indicators: Target: 75% not in care will receive medications.
#2. Outcome: Increase CD4 count and decrease viral load levels for clients receiving and maintaining care under this initiative. Indicators: 75% of clients served with improved CD4 counts.
#3. Outcome: Increase improved health care and decrease hospitalizations for target populations. Indicators: 75% of patients will have improved health care an a decrease in hospital stays

FY 2007 MAI Implementation Plan
GRANTEE: West Palm Beach EMA

Service Priority Name: Dental (Oral Health Care)			**Total Priority Allocation: $100,000**		
Service Goal: To provide Dental (oral Health Care) to Haitians & Afro-Americans					
Objective/s: To provide improved oral health, general health for PLWHA's in Haitian & Afro-American communities that would otherwise not receive oral health care during FY07.					
Community(s) to be Served *List all racial/ethnic minority communities to receive this service*	**Service Unit Definition:** Define *the unit of service to be provided*	Quantity		**Time Frame:** *Indicate the estimated duration of activity relating to the objective listed*	**FY 2007 Funds:** *Provide the approximate amount of MAI funds to be used to provide this service.*
		Number of People to be Served	**Total number of Service Units to be Provided**		
a. Haitians	A patient visit=1 unit	91	275	8/1/07-7/31/08	$50,000
b. Afro-Americans	A patient visit =1 unit	91	275	8/1/07-7/31/08	$50,000
Planned Client-Level Health Outcome(s) and Indicators: #1. Outcome: Improved oral health and general health for PLWHA's that would not otherwise receive oral health care. Indicators: Target: 75% improve oral health care. #2. Outcome: Increase CD4 count and decrease viral load levels for clients receiving and maintaining care under this initiative. Indicators: 75% of clients served with improved CD4 counts.					

Service Priority Name: Food/Meals			**Total Priority Allocation: $100,000**		
Service Goal: To provide food that will meet nutritional requirements					
Objective/s: *PLWHA "s will be able to meet their nutritional requirements along with culturally appropriate foods for the duration of FY07.*					
Community(s) to be Served *List all racial/ethnic minority communities to receive this service*	**Service Unit Definition:** Define *the unit of service to be provided*	**Quantity**		**Time Frame:** *Indicate the estimated duration of activity relating to the objective listed*	**FY 2007 Funds:** *Provide the approximate amount of MAI funds to be used to provide this service.*
		Number of People to be Served	**Total number of Service Units to be Provided**		
a. Haitians	1 food voucher or meal = 1 unit	100	1,050	8/1/07-7/31/08	$50,000
b. Afro-Americans	1 food voucher or meal = 1 unit	100	1,050	8/1/07-7/31/08	$50,000
Planned Client-Level Health Outcome(s) and Indicators: #1. Outcome: Increase enrollment/adherence for those individuals that are not currently receiving primary medical care. Indicators: Target: 75% not in care will receive nutritional requirements and maintain adherence to medications. #2. Outcome: Increase CD4 count and decrease viral load levels for clients receiving and maintaining care under this initiative. Indicators: 75% of clients served with improved CD4 counts. #3. Outcome: Increase improved health care and decrease hospitalizations for target populations. Indicators: 75% of patients will have improved health care and a decrease in hospital stays.					

FY 2007 MAI Implementation Plan
GRANTEE: West Palm Beach EMA

Service Priority Name: Transportation				**Total Priority Allocation: $100,000**	
Service Goal: To provide transportation to medical appointments					
Objective/s: PLWHA's will have access to needed medical care appointments during the FY07 year.					
Community(s) to be Served *List all racial/ethnic minority communities to receive this service*	**Service Unit Definition:** Define *the unit of service to be provided*	Quantity		**Time Frame:** *Indicate the estimated duration of activity relating to the objective listed*	**FY 2007 Funds:** *Provide the approximate amount of MAI funds to be used to provide this service.*
		Number of People to be Served	**Total number of Service Units to be Provided**		
a. Haitians	One way trip = 1unit	75	710	8/1/07-7/31/08	$50,000
b. Afro-Americans	One way trip = 1 unit	75	710	8/1/07-7/31/08	$50,000

Planned Client-Level Health Outcome(s) and Indicators:
#1. Outcome: Increase enrollment/adherence for those individuals that are not currently receiving primary medical care. Indicators: Target: 75% not in care will receive transportation to primary medical care and maintain adherence to medications.
#2. Outcome: Increase CD4 count and decrease viral load levels for clients receiving and maintaining care under this initiative. Indicators: 75% of clients served with improved CD4 counts.
#3. Outcome: Increase improved health care and decrease hospitalizations for target populations. Indicators: 75% of patients will have improved health care and a decrease in hospital stays.

Attachment 7

Part A Program Organization (Staffing Plan) -- MAI Program Organization

The Palm Beach County Board of County Commissioners is the local governmental agency that is responsible for the administration of the Ryan White Part A funds.

The Board of County Commissioners designates the authority of the Part A funds to the County Administrator. An organizational chart illustrating the location of the County Administration and the Department of Community Services who is the Grantee of the Part A Funds is located in **Attachment 8.**

The Ryan White Part A Program Manager is responsible for the day-to-day operations of the grant, which includes distribution of grant funds based on the Request for Proposal (RFP) open competitive process.

The Program Manager also supervises two Program Monitors that conduct on-site visits to service providers as well as writing contracts and preparing reports.

The Financial Analyst conducts fiscal monitoring of all providers and produces all fiscal related reports for the Program Manager and Planning Council.

The Fiscal Specialist is responsible for all program reimbursements.

The Computer Specialist provides MIS support to the providers, technical assistance and training of any new MIS programs.

The Quality Manager is responsible for the quality management program, quality plan, quality assurance committee and ensuring providers provide performance outcome measurements.

The Planning Council Support is subcontracted to the Treasure Coast Health Council.

Attachment 8 & 9

Not Applicable

Attachment 10 – FY 07 Part A MAI

Selected Co-Morbidities and Economic Characteristics
Palm Beach County EMA, 2005

	Prevalence among PLWHA in EMA[1]			Prevalence among EMA General Population[2]		
	Number	Rate per 100,000	Percent Change 2004-2005[3]	Number	Rate per 100,000	Percent Change 2004-2005[4]
Tuberculosis	3	27	-50%	92	7	-8%
Infectious Syphilis	9	82	-18%	31	2	25%
Gonorrhea	18	165	63%	851	67	38%
Chlamydia	20	183	-5%	2,196	172	29%
Hepatitis	249	2,278	-4%	1,472	115	-91%
Intravenous Drug Use	1,221	11,168	2%	5,400	451	Unavailable
Other Substance Abuse	332	3,037	60%	81,000	6,772	Unavailable
Chronic Mental Illness	35	320	315%	Unavailable	Unavailable	Unavailable
Homelessness				5,167	432	Unavailable
Lack of Insurance				236,174	18,900	Unavailable
At or Below 300% of Poverty Level				567,301	46,000	0

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[1] Definitions, Data Sources, and Dates of Data:
Tuberculosis: AIDS cases diagnosed through 2005 with Tuberculosis diagnosed in 2005; Infectious Syphilis, Gonorrhea, Chlamydia: Reported in 2005 among HIV/AIDS patients by the County Health Department (minimal estimate, based on STD client data only); STDMIS; Data through 2005, as of 03/06.
Hepatitis: Any HIV/AIDS case noted with a history of acute and/or chronic Hepatitis and documented in HARS; HARS (local use variable); Data through 2005, as of 04/06.
Intravenous Drug Use: Florida Department of Health, Bureau of HIV/AIDS Surveillance Section (2006). *Table 1b: Background Data Used for the Calculations of AIDS Prevalence and HIV (not AIDS) prevalence (excluding Department of Corrections).* Data through 2005.
Other Substance Abuse: Any HIV/AIDS case noted with a history of substance abuse, e.g., alcohol, methamphetamine, cocaine, inhalants, etc., and documented in HARS; HARS (local use variable); Data through 2005, as of 04/06.
Chronic Mental Illness: Any HIV/AIDS case noted with a history of mental illness and documented in HARS; HARS (local use variable); Data through 2005, as of 04/06.
Homelessness, Lack of Insurance, At or Below 300% of Poverty Level:
[2] Data Sources and Dates of Data:
Tuberculosis, Infectious Syphilis, Gonorrhea, Chlamydia, Hepatitis: Florida Department of Health, Bureau of HIV/AIDS Surveillance Section (2006). *Epidemiological Profile, Palm Beach County.*
Intravenous Drug Use: Lieb (2003)________
Other Substance Abuse: National Institute of Drug Abuse (2003). *National Household Survey, 2003 Supplement: Regional Trends.*
Homelessness: Homeless Coalition of Palm Beach County (2003). *Homeless Survey.*
Lack of Insurance: Florida Agency for Health Care Administration, Office of Medicaid Research and Policy (2004). *Florida Health Insurance Study.*
At or Below 300% of Poverty Level: U.S. Census Bureau (2006). *2005 American Community Survey.*
[3] Data Sources: 2005: Data sources as noted in Footnote 1 above. 2004: FY 2006 Ryan White Title 1 Grant Application.
[4] Data Sources:
Tuberculosis, Infectious Syphilis, Gonorrhea, Chlamydia, Hepatitis: Florida Department of Health, Office of Planning, Evaluation, and Data Analysis (2006). *Selected Sexually Transmitted Diseases (STD), Tuberculosis, (TB), Hepatitis A, B, and C, HIV and AIDS Morbidity, Same Period Comparison, Florida.*
At or Below 300% of Poverty Level: U.S. Census Bureau. *2004 and 2005 American Community Surveys.*

Attachment 11: Other Tables

Table 1: Top Service Category Barriers 1

Table 2: Survey Question 24 2

Table 3: Survey Question 27 3

Table 1

Top Service Category Barriers	Barriers (Can Get, Won't Use) All In Care Respondents n=252			Barriers (Can Get, Won't Use) All Black In Care Respondents n=151			Barriers (Can Get, Won't Use) Haitian In Care Respondents n=49			Barriers (Can Get, Won't Use) Hispanic/Latino In Care Respondents n=37		
	rank	#	%	rank	#	%	rank	#	%	rank	#	%
Clinical Trials	1	22	8.7%							1	12	32.4%
Complementary Therapies	4	14	5.6%									
Counseling Other							2	5	10.2%			
Day and Respite Care	5	12	4.8%	2	9	6.0%	2	5	10.2%			
Dental Care Services							2	5	10.2%			
Health Insurance Continuation				2	9	6.0%						
Hospice							2	5	10.2%			
Mental Health							2	5	10.2%			
Nurse Care Coordination	5	12	4.8%	2	9	6.0%	1	6	12.2%			
Outreach	5	12	4.8%	2	9	6.0%						
Peer Advocacy	2	17	6.7%	1	13	8.6%	1	6	12.2%			
Specialty Outpatient Medical Services	2	17	6.7%	2	9	6.0%				2	6	16.2%
Substance Abuse Outpatient	5	12	4.8%							2	6	16.2%
Substance Abuse Residential	3	15	6.0%							2	6	16.2%
Translation	5	12	4.8%									

Table 2

Out of Care Reasons	All Out Care Respondents n=148		All Black Out Care Respondents n=114		Haitian Out Care Respondents n=26		Latin/Hispanic Out Care Respondents n=7	
	#	%	#	%	#	%	#	%
I am afraid of being identified as HIV positive.	59	39.9%	41	36.0%	6	23.1%		
I am too embarrassed or ashamed to go.	54	36.5%					4	57.1%
I know where to go but I do not want to go there.	54	36.5%	36	31.6%				
I do not have medical insurance and can not afford care.	51	34.5%	38	33.3%	14	53.8%	5	71.4%
I have heard bad things about the medications and their side effects.	51	34.5%	39	34.2%	6	23.1%	4	57.1%
I am not ready to deal with my HIV status.			36	31.6%				
I do not have transportation.							4	57.1%
I do not want any bad news about my health.					5	19.2%		
I do not know that I am eligible for free care.					5	19.2%		
I am scared of immigration or other legal issues.					9	34.6%		
I prefer to use Santeria or Voodoo.					5	19.2%		

Survey Question 24. What are the reasons that you are not in primary medical care? (check all that apply)

Table 3

Survey Question 27. What would be some reasons you enter primary medical care? (check all that apply)								
Reasons to Enter Primary Medical Care	All Out Care Respondents n=148		All Black Out Care Respondents n=114		Haitian Out Care Respondents n=26		Latin/Hispanic Out Care Respondents n=7	
	#	%	#	%	#	%	#	%
I get sick and know I need care	96	64.9%	72	63.2%	15	57.7%	5	71.4%
I am ready to deal with my illness.	50	33.8%	33	28.9%	4	15.4%	6	85.7%
Someone else with HIV/AIDS reaches out to me.	45	30.4%	33	28.9%				
I find a doctor or medical facility that ensures my confidentiality	38	25.7%	25	21.9%			4	57.1%
I find a doctor or medical facility I like.	31	20.9%						
I am able to deal with other problems in my life that are keeping me out of care.			27	23.7%	9	34.6%		
I find a doctor or clinic that is culturally sensitive and speaks my language.							4	57.1%